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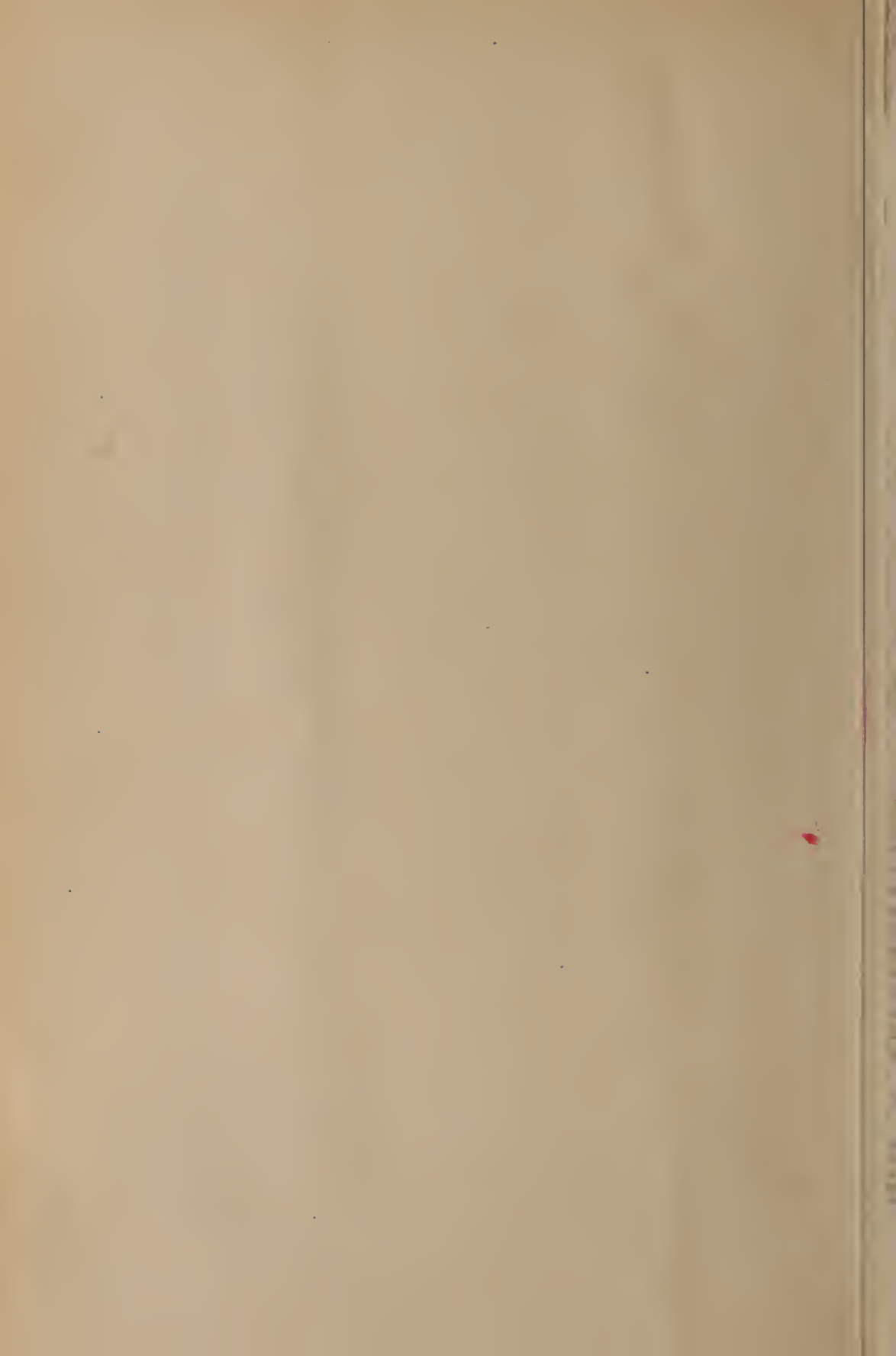
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume VII

St. Augustine and Jacksonville, Florida, July, 1920

Number 1

ORIGINAL ARTICLES

SURGICAL TREATMENT OF CON- GENITAL HYPERTROPHIC- PYLORIC STENOSIS.*

JOHN S. HELMS, A.B., M.D., F.A.C.S.,

*Director of Division of Surgery,
Bayside Hospital,
Tampa, Fla.*

The surgery of children holds an increasing interest. This is due largely to the better results which have been obtained in this field of work and to a better understanding of the peculiar nature of the surgical diseases of children. Children as a rule lend themselves to surgical operations with fair safety provided they are not too prolonged.

The open method of ether anæsthesia seems to be the best form of anæsthetic, if brief. Local anæsthesia is coming more into use for this class of work, although its field of application is not so wide as in adults.

One of the most interesting surgical conditions encountered amongst children is congenital hypertrophic-pyloric stenosis. It seems this condition has been very poorly understood, and the operations therefor devised have carried a high mortality on account of their complicated technique. With a simpler technique the mortality has been greatly reduced.

The etiology of this condition seems to be little understood, notwithstanding the great number of cases that have been observed and the great number of workers in this field who have theorized about its causation. The pathological condition consists of the thickening of the pyloric muscle to such a degree that complete obstruction is brought about and consequent starvation of the patient.

Hystologically, the muscle is normal. The first causative factor seems to be that a pyloric spasm is brought about in a reflex way which results finally in a hypertrophy of the muscle and complete stenosis.

Gray and Pyrie (*Lancet*, September 20, 1919, page 526) seem to believe that congenital pyloric hypertrophy is due to a prolonged antenatal spasm induced by hyperadrenalism. "The pyloric obstruction is completed by two secondary influences: First, (a) retention gastritis with consequent swelling of the mucosa; (b) added spasm due to several causes, foremost by phimosis. The final results of the closure of the pyloric orifice are (a) absence of acid chyme in the first part of the duodenum, leading to (b) failure of secretion formation, leading to (c) suppression of pancreatic secretion. These factors themselves further induce inhibition of the normal pyloric relaxation and establishment of the 'vicious circle.'

"Sex incidence is about equal, phimosis being the determining factor in the onset and severity of symptoms in the large proportion of male subjects of pyloric hypertrophy."

The diagnosis of the condition rests upon four or five points:

First—Projectile vomiting.

Second—Visible peristalsis.

Third—Rapid emaciation.

Fourth—Constipation.

Fifth—A palpable tumor.

The indications for operation as stated by some authorities should always carry with it a palpable tumor. I do not believe, however, that the detection of the presence of a palpable tumor should always be the determining factor. A combination of all the other signs above mentioned, taken with the failure of medical treatment covering a period of say twenty-four to forty-eight hours, should

*Read before the forty-seventh annual meeting of the Florida Medical Association, at Daytona, May 12, 13, 1920.

constitute indications for operation. My experience, however, is limited to three cases. In one of them it was impossible for anyone connected with the case to palpate the tumor although it was present, as was demonstrated by operation. The other two presented tumors which were capable of palpation.

The condition should be recognized as early as possible and early operation resorted to, as it is the only insurance of success. The form of operation first resorted to in the early observance of this condition was gastro-enterostomy. The immediate mortality was very high, averaging around 50 per cent or above. The mortality has been reduced by the Rammstedt operation to 17 per cent and below, in the hands of some operators. We have had no mortality following operation in these cases, and no case has been refused operation.

Rammstedt's operation is a very simple procedure, requiring an opening through the upper right rectus of about one and a half to two and a half inches, delivery of the tumor only, section of the muscle longitudinally with the stomach down to the mucous membrane, care being taken not to open the mucous membrane. A tag of fat, or the edge of the omentum, may be stitched over the cut edges in order to avoid adhesions. I have modified the Rammstedt operation by taking off the sharp edges of the incision above and below, and bringing up the tail of the omentum and stitching it over the raw surface. The operation may be executed in ten to fifteen minutes with perfect safety.

Strause, of Chicago, has modified Rammstedt's operation, making it a more or less complicated operation, by separating the mucous membrane from the muscle about three-quarters of the distance around and splitting the muscle in such a way as to bring up the flap from underneath the cut edges of both sides with suturing of these flaps in the midline, in this way reconstructing the pylorus and thereby considerably enlarging its circumference. It would seem that the Rammstedt being a more simple operation

is more safe, and the results are absolutely satisfactory.

The postoperative care of these cases is very simple. Most of the cases are breast-fed infants, and they should be allowed to nurse a limited amount soon after recovery from the anaesthesia. It is well to give just before or after each feeding, a quantity of 2 per cent sodium citrate solution. There is usually little vomiting and the infant rapidly gains weight and strength. Where much vomiting occurs it is likely to be due to incomplete division of the constricting pyloric muscle.

It may be stated in fairness that Fredet, of Paris, really conceived the idea and performed the first operation on the pylorus for relief of this condition. His operation was modified by Rammstedt. The operation should therefore be termed the Fredet-Rammstedt operation, as has recently been pointed out by Wm. A. Downes, of New York.

It is my judgment that the general practitioner should study the diagnosis of this condition, and cause the case to be brought to operation before it is too late. In this way the mortality would be reduced.

HYPERTROPHIC-PYLORIC STENOSIS IN INFANCY.

J. C. DAVIS, JR., M. D.,
Quincy, Florida

I shall not enter into a discussion of these cases in this paper, but shall dismiss that phase by saying I believe the disease a surgical one and the operation should be conducted as soon as the diagnosis is made. Holt has changed his attitude in favor of surgical interference since his article in 1914. He and his coworkers, also, changed their opinion regarding classification and came to the conclusion that they are all true hypertrophy of the pylorus, instead of pylorospasm, and that the pathological condition is present and responsible for the pylorospasm, rather than a pylorospasm being functional, neurotic or idiopathic, later producing the hypertrophy, and that this change of opinion

has been brought about by frequent necropsies and the almost universal adoption of the Rammstedt operation. I believe the condition to exist more frequently than expected, because the diagnosis has not been made. I have had no less than two physicians tell me recently they now recalled cases that succumbed unrecognized. In reporting this case I have nothing new or original to offer, but should this paper be responsible for a correct diagnosis being made early, I shall feel well repaid for making the report.

Baby G. G., male, breast fed, weight at birth eight pounds, second child. Illness began at age five weeks six days, weight twelve pounds. The child was healthy and vigorous up to the time vomiting began. The vomiting was of sudden onset.

I saw this child in consultation with Dr. Galphin, of Havana, four days after onset. At this time the child had vomited after each feeding, which was projectile in character, had been obstinately constipated, diminished amount of urine. The doctor gave me the above history before I saw the child. I suggested that we would in all probability find gastric-peristaltic waves after a feeding, and that in my opinion we would find a typical case with classical symptoms of hypertrophic-pyloric stenosis. After exposing the child's abdomen and noticing that it was quite flacid, I had them give the child two ounces of sweetened water and watched for the gastric wave. In less than three minutes after taking the water the child showed typical gastric peristalsis crossing the median line; this was so distinct as to cause a considerable bulging of the left rectus muscle with one continual wave after another for about ten minutes, when there occurred a reverse wave which emptied the stomach and the vomit projecting two or three feet from the child. This clinched the diagnosis in my mind. No tumor was palpable at this time. According to the various authorities I had read on the subject since 1914, I reluctantly advised that we do a Rammstedt operation. This the parents did not see their way clear in submitting to without first a chance with medi-

cal treatment. With this condition staring us in the face, Dr. Galphin and I came to the conclusion that we would try liquid petrolatum in dram doses, three times daily, also two minims of benzyl-benzoate in sweetened water every four hours, with the idea if this was only a functional reflex pylorospasm, that by gentle lubrication and relaxation we would probably theoretically be doing something. It is interesting to note that after this medication some food began to pass from the stomach to the bowels. Vomiting became less often and the child remained at a standstill in weight for one week; after which he began to lose two ounces daily for a few days, but going twelve hours without vomiting. In fact, at one time he went twenty-nine hours without vomiting, and in two days gained four ounces, after which he began losing two ounces daily, until he weighed only nine pounds. At this time I was able to convince the parents that if the child was not gaining in weight he was losing—aside from the fact they could see the amount of the daily loss. Three weeks now had elapsed since the beginning of the symptoms above mentioned. At this time I was able to palpate a small tumor at the pylorus. The child was brought to the hospital and a Rammstedt operation done.

A one-half of a 1 per cent novocain solution was the anæsthetic employed. An incision three inches in length in the median line above the umbilicus was made. On examination, the pylorus muscle was found greatly enlarged and a very hard cartilaginous-like tumor was demonstrated. This was incised on the posterior part, beginning at the cardia side and extending toward the duodenum. The muscle was three-eighths of an inch in thickness. The incision was one inch in length. The muscle was gradually separated from the mucous membrane in its entire length, so that the mucous membrane bulged at least one-eighth of an inch the whole length of the incision. The abdomen was closed in the usual manner. Operation was completed in fifteen minutes. The child suffered very little shock and immediately after leaving the

table was given one dram of mother's milk with one dram of barley water. Feedings were continued every three hours, increasing one dram of breast milk every other feeding until we were giving one ounce every three hours during the day and every four hours at night. After five days the child was allowed to nurse the mother. Castor oil was given twenty-four hours after operation. The child left the hospital on the tenth day with eight ounces gain in weight. The child made a complete recovery.

AMERICAN COLLEGE OF SURGEONS.

FRANKLIN H. MARTIN, M.D., F.A.C.S.

(Continued from June Number.)

III. THE CONTINENT.

The *Conquest of Peru* has left in the minds of civilization a romantic impression of South America which fits well one's imagination during a visit to the whole continent. I believe one of the great charms of South America lies in its barren shore line and the occasional oasis in the form of an important seaport. From Panama, where the second break of the trip occurs, Kingston being the first, there is a two days' sail due south without a sight of land, and on the third day one comes abreast of the great promontory of Ecuador, and from there to Valparaiso he is in constant sight of the dry, brown coast range of mountains, with an occasional glimpse of the snow-capped second and more important range. The first stop south of Panama was at the port for Lima—Callao. The Pacific is so undisturbed and calm that the ships anchor in the open sea and transport their passengers to the dock by row boats or little launches, loading and discharging their cargoes from lighters. Eight miles from Callao, which is a flat little seaport town of about four thousand inhabitants, and connected with it by a broad boulevard and by trolley, is the capital of Peru—Lima. This city and its seaport are typical of all seaport towns on the western coast, as far south as Valparaiso. The mountains surrounding

the coast are absolutely barren of foliage; rain is almost unknown; and the sun-dried mountains have crumbled, and everywhere at their base, except where the sea washes, is a long, straight line of deep brown dust that constantly sifts down from above.

Lima is typical of the nearby inland cities. They are always the source of water supply and are real oases in sterile rock, mountain-bound valleys. These valleys "bloom like the rose" as soon as water is turned into them. Growing in the dust-covered earth are royal palms, fruit-bearing trees of all kinds, and a wealth of foliage and tropical flowers. Every house has its patio and each is the central attraction of the habitation. And so with Arica and its inland oasis city—Tacna; also Antofagasta, Valparaiso, and Santiago.

From Valparaiso we traversed the continent and landed at the metropolis of South America—Buenos Aires, and made the last reach by viewing the Atlantic Ocean at Montevideo. It is no small experience for the traveler who is familiar with the Trans-Andean route to make it again and again, and how much more eventful it is for one traversing it for the first time. An unusual ride from the scenic standpoint is the first arm of the journey to Los Andes, Chile, an oasis city. The climax is reached, however, in the climb by cog railroad to the top of the Andes, penetrating by a two-mile tunnel a lofty final obstruction, the road reaching a height of 10,470 feet, with the highest peaks of the two continents towering in grandeur, snow-capped, far above the dizzy height. Then the descent on the Argentine side to Mendoza, the center of the grape-growing province. Finally, one enters a special train of sleepers and diners on the broad gauge road, which takes the traveler across the broad pampas, which are covered with a wealth of wheat, corn, and grazing cattle and sheep, and conveys him to Buenos Aires. An overnight ride on a comfortable steamer of palatial equipment completes the trip to Montevideo.

In this continental journey one traverses two proud republics and enters a third. In

crossing the first, Chile, he enters two cities of importance and travels among the foothills of a mighty mountain range, with deep valleys and raging torrents of rivers, and appreciates the interest that is excited by a new civilization in a strange land, and all the picturesqueness of an Alpine scene. This develops finally into the grandeur of the Canadian Rockies, as one crosses the divide, and there is revealed Aconcagua, the premier peak of the continent, with its worthy satellites. Then one begins the descent, picking one's way over almost impossible abysses on a roadbed that is the pride of engineers of international fame; and at last a great empire of agriculture that reminds one of the plains of the Dakotas, Montana, Minnesota, and Illinois, arriving at a metropolis that brings to mind Rome and Paris rolled into one, which houses a people who are proud of their great country and know how to welcome the stranger.

IV. OUR WELCOME.

We did not have to wait until we reached South America to feel the warm handclasp of welcome. Standing on the dock at Colon was our friend, and the official Sanitary Officer of the Canal Zone, Colonel H. C. Fisher. We last knew him in the Surgeon General's office in Washington during the strenuous days of the war. He was in uniform, appearing almost boyish in his white helmet, and his face was good to look upon. We dined with him that evening, together with our wives, meeting at dinner other friends of war time—Colonel Greenleaf, Sanitary Officer of Panama; and Colonel Hess, in charge of the Government Hospital at Balboa. Afterward at a reception we met the principal members of the medical fraternity of this little Republic. We were particularly interested in the inspection of the City of Panama the next day, under the guidance of Dr. Braithwaite.

On anchoring at Callao, the port for Lima, our ship was soon besieged by launches, and in one of the first was Antonio Grana, Esq., a business man of Lima, who came to pay his

respects to Dr. Mayo. His launch was followed by another with a group of Lima surgeons, representing the Sociedad de Cirugía del Perú. We were informed by Drs. Aljovin, Grana, Gastaneta, Denegri, and Macedo of the committee that we were to take automobiles from Callao to Lima, and become the guests of the Society at the Hotel Maury during our three days' stay at Lima. The eight-mile trip by motor along the sea boulevard was most enjoyable, as it gave us the first shore glimpse of this rainless country. Our days were full, the intervals between conducting the business of our mission being crowded by hospitable attentions which were accorded to us by the surgeons of Lima and Callao, the government of Peru, and our own United States representatives residing there. Before disembarking, we were welcomed by our American Consul and the Chargé d'Affaires, representing the American Embassy, who bore invitations for us to visit the Minister of Foreign Affairs and the President of the Republic that afternoon. Dr. Guillermo Gastaneta was our host at luncheon at the Botanical Gardens that day, and a group of surgeons of Lima were additional guests.

At four o'clock, Mr. William Walker Smith, the Chargé d'Affaires, visited us and we made official calls upon the Minister of Foreign Affairs, and afterward on the President of the Republic. The palace of the President was built by Pizarro in about 1540, and occupied by him as his official residence. While waiting we were shown the spot where Pizarro was assassinated, and were then conducted by relays of red-coated officials to the executive apartments. There we were met by the secretary, who took us into the audience chamber where the President greeted us. He is an attractive, vivacious man of rather small stature who speaks English perfectly, and we were soon engaged in an animated discussion of our mutual friend, Major General William C. Gorgas. The President reminded me of our own Secretary of War, Mr. Baker—the same keen, intellectual type of man.

That evening Dr. Juvenal Denegri, president of the surgical society, gave an official dinner that was attended by about sixty men and women. This was an elaborate banquet given at the Botanical Gardens, and it was an affair that emphasized the exquisite taste of these delightful people. An address directed to the President of the College, Dr. Mayo, was read by Dr. Denegri. Dr. Mayo formally responded. This occasion added to the cordiality of our reception and stamped it as official. The next day we, together with the ladies of our party, were entertained by Professor Miguel C. Aljovin at a luncheon at his home, the first luncheon in which an attempt was made to give us Peruvian dishes exclusively. The dining room opened onto a patio filled with flowers, growing palms, and cages of highly-colored birds who vied with a native mandolin orchestra playing Peruvian airs. Here we succeeded in getting the home atmosphere of the people of Lima. The next day Dr. Denegri entertained us at luncheon at the Union Club, and in the evening we were the guests of Antonio Grana, Esq., at a dinner at his interesting residence. In the afternoon we attended a garden party at the American Embassy given by Mr. and Mrs. William Walker Smith. There are many memories that will frequently hark back to our visit in Lima. The unobtrusive but continuous hospitality of these people, with their cosmopolitan ways and cultivated minds, is something that we can never forget. Our welcome was not by any means wholly official, as there was much that was personal, because of the affection that many Peruvians have for our chief, Dr. Mayo. Not until we had been deposited on our ship, loaded with fruits and other dainties, and our adieus had been said, did we realize to the full the friendships that we had made.

And this was but the beginning of entertainments that continued wherever we touched the continent, and at all times on our land trips. Even at the small ports we were greeted by officials and physicians. At Arica we had been prepared by a wireless from our American Consul to meet the Governor of

the Province, the *intendente*, Mr. Edwards, of Tacna. At Arica a special coach awaited us, consisting of an enclosed body built on a Ford auto, with flanged wheels that traversed the railroad. We were conveyed to it by the Consul, Mr. Cameron; the Governor; and Dr. Tomes Aravena, of Arica. The invitation included Dr. and Mrs. Mayo, and Dr. and Mrs. Martin. On arriving at Tacna we were greeted by Mr. Edwards, the *intendente*, Mr. Eliot, the English Consul, and two physicians. Our luncheon in the palace of the *intendente*, with his wife, four daughters and a son, and guests, was one of the most interesting experiences of our trip. We viewed the beautiful gardens afterward, and then were taken by Mr. Eliot to inspect a new hospital of which he has every reason to be proud. This city of Tacna is thirty miles from the sea, at an altitude of 1,800 feet, and is an oasis with a population of ten thousand.

At Antofagasta and Iquique we were carefully looked after, at the latter port by Dr. J. E. Villalon Dia and Dr. Germán Aliago, both local surgeons of renown; and at the former city, Antofagasta, by Dr. W. F. Shaw, an American stationed at the copper mines at Chuquicamata, the captain of the post, and Dr. A. Arturo Pemjean. We were shown the clean city, inspected a hospital and were entertained at luncheon in a large public garden.

At Valparaiso the first launch brought a distinguished group of men who had come to greet us, pay their respects, and take us to the dock. They were lined up and we were introduced to Dr. Edwyn P. Reed; Dr. Vincenti Daguino, Viña del Mar, president of the medical society of Valparaiso; Dr. Gaston Lachaise, secretary of the medical society of Valparaiso; Dr. R. de la Fuente, Dr. Alberto Adriasola, and Dr. Prain, of Valparaiso; Professor Correo Pardo, Professor José Ducci, Dr. Luis Vargas, and Dr. Juan de Dia, of Santiago. Our stay at this port was short, but we visited the town, and before taking our Trans-Andean train at noon we had refreshments at the Naval Club with Dr. Adriasola, Surgeon General of the Chilean Navy, as our host. In ten days we

returned to this city in the special Pullman that the government had furnished us and were literally carried away by the committee of surgeons which had greeted us on our arrival in port.

At Viña del Mar, a suburb of Valparaíso, they intercepted us and conveyed us in automobiles to a tropical garden where, in the shade of enormous trees, a wonderful banquet table was spread. A large oval canopy was stretched overhead, and in the background were the American, English, and Chilean flags. The entertainers were headed by Dr. Vincenti Daguino, who made us a formal address which was responded to briefly by Dr. Mayo, Dr. Martin, Dr. Reed, Dr. Muenich, Dr. Avarosus, and Dr. Adriasola. Then our hospitable friends conducted us to our dock and by special launch took us to our ship which had been awaiting us for two weeks.

At Buenos Aires we were greeted both officially and medically. Reporters boarded our train about an hour out of the city. On alighting at the station we were immediately greeted by Mr. Welles, representing the American Ambassador, who formally conveyed that official's greetings to us. Then appeared a delegation of doctors from the Faculty of Medicine. General introductions were indulged in. Heading the group were Dr. Marcelino Herrera Vegas, Dr. Marcelo T. Vinas, Dr. Pedro Chutro, and Dr. José Arce. After much flashlight photographing on the part of a battery of newspaper men, we were conveyed to the Plaza. There for two hours in the corridor of the hotel we held an informal reception and met many of the physicians and surgeons of Buenos Aires.

There was much for us to see and accomplish in this metropolis, and our professional and official social entertainments were many and most interesting. The first day after inspecting hospitals we were "breakfasted" at the Jockey Club, where we were especially distinguished by having large goblets of actual ice water served in honor of Dr. Mayo. The luncheon was much appreciated as our hosts had been our guides

during the morning. The Jockey Club is the pride of this city, and is not surpassed anywhere. It reminded us of Paris, New York, or London.

At noon we paid our respects to the American Ambassador, Mr. Frederic Jesup Stimson, a Boston man of the type of Senator Lodge, but much younger. Our greeting was most cordial and we had an enjoyable call, conducted without interpreters. We were invited to tea for Sunday afternoon.

Dr. Chutro took us on a unique trip in the afternoon to El Tigre. This is a freak of nature of LaPlata which converts a large area of land adjacent to it into many islands by offshoots which resemble artificial canals. These islands are covered with summer residences and luxuriant fruit orchards.

Saturday was enjoyed with an excursion by automobile as guests of Dr. Vegas to his *hacienda*, or landed estate. It consists of forty-five square miles of agricultural territory lying about half way between Buenos Aires and LaPlata. We were accompanied by Dr. Cranwell and his daughter, and Dr. Pasman and his brother. This is one of the largest and most attractive landed estates in Argentine. This day's visit to Dr. Vegas' estate, which is one of the side interests of this remarkable surgeon, is worthy of a separate chapter. However, our day was not completed until we motored on to LaPlata. On the way we could fix in our minds a few commercial facts regarding this estate, on which there are one hundred thousand cattle, two hundred thousand sheep, and other animals in proportion, and on which is raised quantities of grain, corn and produce.

On reaching LaPlata we were the guests of the president of the Universidad Normal de La Plata. We breakfasted in one of the corridors of the University. The professor of anatomy, Dr. Pedro Belou, made an address in Spanish, to which we responded in English. We were then driven about the beautiful but deserted city of LaPlata and returned to Buenos Aires by motor. It was a distinguished group that we met that evening at dinner at the American Embassy. One

of the interesting men we met on this occasion was the *intendente* of Buenos Aires. On Sunday another estate was visited by Dr. and Mrs. Mayo and Mrs. Martin as the guests of Dr. Pasman and Dr. Cranwell. They were entertained at luncheon, and then taken to the races, which are the most attractive Sunday diversion of these people. Later they took tea at the American Embassy.

Montevideo welcomed us with open arms. A letter from our Ambassador, Mr. Robert Jeffery, in Montevideo, to our Ambassador in Buenos Aires had given us advance information to the effect that a committee from the Faculty of Medicine would welcome us. Accordingly, when the gang plank of our steamer connected us with the dock at Montevideo, the first to come over it was a committee headed by the Ambassador, Mr. Jeffery. The committee of surgeons and physicians consisted of Dr. Enrique Pouey, Dr. Gerardo Arriabalaga, Dr. Horacio Garcia Lagos (who speaks English fluently), Dr. Alfredo Navarro, Dr. A. Ricaldoni, dean of the Faculty of Medicine, Dr. Lorenzo, Dr. Carlos A. Belliure, Dr. Alfonso Lamas, and Dr. Julio Nin y Silva. General introductions were in order, after which we filed onto the upper deck and were duly photographed by newspaper men.

We were then driven to Montevideo where we inspected the medical school, accompanied by about seventy-five members of the faculty and students. Later we drove about the city and were shown with pride the new sea boulevard which is named for President Wilson. After transacting some business, we were taken to the Parque Hotel where we lunched with a group of government officials and medical men. The luncheon was an elaborate one served in the great dining room of the hotel, in which a large number of other people were being served, including a luncheon party given by Mrs. Jeffery for the ladies of our party. At the end of the feast the president of the faculty read an address to the guests which was translated into English by Dr. Ernesto Dowling. Dr. Mayo responded, followed by Dr. Martin. These

two talks were, in turn, translated into Spanish. Mr. Jeffery arranged an interview for us with the Minister of Foreign Affairs in the afternoon. We were very graciously received, and the Minister expressed genuine good will toward our country. He reminded us that Uruguay had followed us into the great war because Uruguay looks upon the United States as its protector against foreign aggression, and when the United States feels compelled to enter European wars, Uruguay automatically follows. Hence she broke diplomatic relations with Germany immediately after our declaration of war. He regretted very much that the President of the Republic was away for the day, and he conveyed to us the President's regrets. The importance of our visit from the point of view of the government may be judged by the fact that this Minister, corresponding to our Secretary of War, was at the ship that night to see us off. Greater cordiality than we received could not have been extended to anyone in the short time we had to spend in Montevideo.

The next morning we were met by many of our friends at Buenos Aires, in spite of the fact that we had but a few minutes to spend in transferring from the Montevideo boat to our transcontinental train. We arrived in Los Andes, Chil , the following evening. At this point we were to change from the narrow gauge Andean train to the normal gauge Chilean train. The Governor called to inform us that he had instructions from his government in Santiago to look after our comfort and to attach to our train a special Pullman coach for the use of our party while in Chile. He then introduced us to the transportation chief who he said would accompany us. This was most welcome news as our party was much fatigued after the exciting journey. Fortunately the coach accommodated more than our immediate party, and we shared it with our other American fellow travelers.

At nine o'clock the next morning we were met at the Hotel Savoy in Santiago by a committee of local surgeons. Heading the delega-

tion were Professor Gregorio Amunategui, Dr. José Ducci, secretary of the Faculty of Medicine, Dr. Correa Pardo, Dr. Victor Koerner, Dr. Francisco Navarro, and Dr. Jerman Valenuela. We were whisked off to an inspection of hospitals and medical schools and ended up at the home of Professor Amunategui for a luncheon which was given by himself and his wife for our ladies and a number of medical men, including also our Ambassador, Mr. Joseph H. Shea. This was another enjoyable luncheon of the formal type that was made unusually pleasant by its family character. Dr. Amunategui is another of the cultured type of Spanish gentleman that wins one's heart by his genial hospitality and his genuine cordiality. In the evening the members of the Faculty of Medicine and their wives gave a large dinner for us in the restaurant on the famous island mountain, Cerro de Santa Lucia. This was a fitting finish for our official visit to this capital.

The next day we boarded our special train and were accompanied to Valparaiso by a brother of Dr. Lucas Sierra, the latter being in Europe, and Dr. José Ducci. We said goodbye to our friends who had gathered at the station to see us off and started for the coast. The final curtain was rung down on our entertainments when we again reached Lima on our return. A wireless had been received by us asking that we become the guests at a luncheon at a seaside resort between Callao and Lima, and witness a bull fight the following day, Sunday and Washington's birthday. We felt that this would be a fitting climax to a continental trip of two surgeons.

The pace had been a fast one. We reached Lima on January 22. Our official visit to South America, occupying just one month, was ended. From our previous landing here until our escort left us at six o'clock on February 22, we had been in the hands of committees, civil and governmental, that had kindly but persistently entertained us. We had visited Lima, Santiago, Valparaiso, Buenos Aires, and Montevideo, and had crossed the continent twice from ocean to

ocean. No company or commission has ever been entertained more royally, more dignifiedly, or more hospitably. At every station we were shown attentions that indicated that our own government had neglected no opportunity to impress upon our hosts the importance of our mission, and the governments of the countries that we visited were not slow in responding. Mr. William Walker Smith at Lima, Mr. Joseph H. Shea at Santiago, Mr. Frederick Jesup Stimson at Buenos Aires, and Mr. Robert Jeffery at Montevideo, our ambassadors and envoys, had neglected nothing which emphasized the importance of our visit. And, best of all, what can we say of the entertainment that we received from the surgeons of South America on our own account? It has been a proud month to the writer of this sketch to see our president and chief, Dr. Mayo, honored everywhere and always. No conquering hero has ever been accorded more royal treatment. "Mayo" has become a household word in four countries where before it was only known by reputation. This visit we hope will be the foundation for the establishment of a more personal friendship between the professions of our two continents.

(To be concluded.)

PROPAGANDA FOR REFORM.

AN INSIDIOUS INFLUENCE. — A knock at the door. A gentleman with a grip full of samples and literature is ushered in. After a pleasant chat in which you are "informed" about the action of the particular remedies in which he is interested, he leaves you samples and departs. You turn to New and Non-official Remedies and find no mention of his remedy. Why? Because the Council on Pharmacy and Chemistry of our national organization has investigated the article and found sound reason why it should not be used by the profession, or else, the manufacturer did not deem it advisable even to submit the article. (*Minnesota Medicine*, September, 1919, p. 355.)

HEPATOLA.—This was declared a fraud by the federal authorities in 1917, and the Hepatola Company was denied the use of the United States mails. It is still being sold in Canada. Hepatola is one of the many treatments claimed to remove gallstones. Analysis showed Hepatola to be the same old gallstone trick—that of giving the patient a large dose of some bland oil and following it up with a saline. The soapy concretions that are voided following this dosing are the “gallstones.” Hepatola is essentially the same as “Fruitola” and “Mayr’s Wonderful Stomach Remedy.” (*Jour. A. M. A.*, March 13, 1920, p. 752.)

PLATT’S CHLORIDES.—The Council on Pharmacy and Chemistry reports that Platt’s Chlorides is inadmissible to New and Nonofficial Remedies because its composition is uncertain and indefinite, and because the claims made for it are exaggerated and misleading. The A. M. A. Chemical Laboratory analyzed a specimen purchased in 1911 and one purchased in 1919, and reports that while both contain aluminum salt and zinc chlorid, they differ considerably in composition and the latter contains a very small amount of mercuric chlorid. In the past, the advertising for Platt’s Chlorides has suggested more or less directly that, as chlorinated lime (bleaching powder) may be made to give off chlorine gas which disinfects, so the air in a room may be disinfected by evaporating Platt’s Chlorides. From the analysis of Platt’s Chlorides it is evident that when the preparation is evaporated under ordinary conditions, only water vapor escapes. Whatever disinfecting or germicidal action the preparation may possess is exercised only when the solution is brought in direct contact with the substance to be disinfected. The aluminum and zinc salts present may be useful as deodorants, but they are not effective as germicides. The small amount of mercuric chlorid is hardly to be considered as materially increasing its efficiency. (*Jour. A. M. A.*, March 27, 1920, p. 903.)

LOOK UP ITS RATING.—The Council on Pharmacy and Chemistry was created because the complexity of modern medicine

makes it a physical impossibility for physicians to know the scientific status of the many proprietary remedies which are on the market. As commercial agencies, such as Bradstreet and Dun, report on the commercial probity of individuals and firms, so the Council on Pharmacy and Chemistry reports on what might be called the scientific probity of proprietary and unofficial pharmaceutical products. The commercial agency issues, at no small expense to its customers, rating books; the Council on Pharmacy and Chemistry issues, at a nominal price, “New and Nonofficial Remedies.” The commercial agency, for a substantial fee, will furnish reports on business concerns; the Council on Pharmacy and Chemistry will, without any expense to the profession, furnish reports on proprietary products used for the relief or cure of human ailments. (*Jour. A. M. A.*, April 24, 1920, p. 1171.)

ARHOVIN OMITTED FROM N. N. R.—Arhovin is a solution of diphenylamin, thymol benzoate and ethyl benzoate marketed by Schering and Glatz, Inc. The Council on Pharmacy and Chemistry reports that it was omitted from New and Nonofficial Remedies because the therapeutic claims made for the preparation were unwarranted. (Reports Council Pharmacy and Chemistry, 1919, p. 66.)

ELARSEN OMITTED FROM N. N. R.—Elarsen, now sold by the Winthrop Chemical Co., Inc., was formerly sold in the United States by the Bayer Co., Inc. It was admitted to New and Nonofficial Remedies in 1914. The Council on Pharmacy and Chemistry now reports that Elarsen has been omitted from New and Nonofficial Remedies because it is sold under unproved and, consequently, unwarranted claims and because, in the light of investigation, it is an unscientific and relatively useless article. The Council also reports that Elarsen has not been shown to have advantages over Fowler’s solution but that, in some respects at least, it is inferior. (Reports Council Pharmacy and Chemistry, 1919, p. 75.)

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CASE RECORDS.*

CASE 6211.

A Canadian housewife of thirty-nine entered September 3, 1919.

F. H. Her father died of heart trouble, her mother of arteriosclerosis, one brother and two sisters of tuberculosis, her first husband of aneurism. One child had Pott's disease. She had had three miscarriages between pregnancies, and had lost one child at nine weeks of "stomach trouble."

P. H. General health not very good. At fourteen had an abscess of the left ear for six months. In 1915 and again in 1917 she had tonsillitis, each time about two weeks. Tired and weak from time to time. Records of the Out-Patient Department, April, 1917, reported weakness and pallor since a miscarriage six months previous. Marked secondary anemia. Wassermann negative. In January, 1918, red count was 4,000,000, hgb. Tallqvist 40 percent. Marked achromia, poikilocytosis and anisocytosis. Was given Blaud's pills. May 2, 1918, reported weakness, loss of weight and copious flowing since the previous October. Hgb. 75 per cent. In autumn of 1918 had influenza. Since then had been troubled with dyspnea, palpitation, and precordial pain and some pitting edema of the ankles when on her feet a good deal. In December, 1918, red count 1,168,000. Poikilocytosis and polychromatophilia. July 10, 1919, felt weak and showed a lemon-yellow pallor. Hgb. 10 per cent Tallqvist. Smear showed typical secondary anemia. Five years ago weighed 148 pounds, her best weight. Usual weight 142, present 130 pounds. Loss had been previous to the past summer.

Habits. Good.

P. I. Two years ago began to have menorrhagia. Flowing had gradually increased in duration and amount to nine days of excessive flowing when she had to stay in bed, followed by two weeks of moderate flowing.

*Published in THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION with the permission of the Massachusetts General Hospital.—Ed.

Next Meeting—Pensacola—May, 1921

During the last week the discharge became more watery. For two months had urinated three times at night and had had a good deal of dull pain in the left flank on urination, with questionable radiation to the leg. Last period ended August 22d. Flowing had begun again the day of admission. Had had a good deal of leucorrhea.

P. E. Very poorly developed and nourished. Skin and mucosæ very pale, with a lemon-yellow tinge. *Lungs*: slight dullness and bronchovesicular breathing at the left apex in front. *Heart*: P_2 greater than A_2 . Systolic murmur all over precordia, of greatest intensity just to left of sternum. *Abdomen*, *pupils* and *reflexes* normal. *Pelvic*: Badly lacerated perineum. Rectocele and cystocele. Some reddening of the meatus. Uterus apparently enlarged, but finger examination of the vaults, etc., impossible because patient would not relax. Cervix bilaterally tender and torn into broad ligament on the left. Moderate erosion. Vaginal wall very lax and redundant.

T. 97.9° - 100° . *P.* 70-100. *R.* normal. *Urine* negative. *Blood*: Hgb. 35 per cent Palmer. *Wassermann* negative.

September 4th the hgb. was 10 per cent Tallqvist. The condition grew rapidly poorer. September 9th she went to the Huntington Hospital for radium treatment, returning the following day. September 11th there was slightly less flowing. September 12th transfusion of 500 c.c. was done. Hgb. was 35 per cent before it, 31 per cent immediately afterward and 42 per cent September 16th. There was irregular flowing for the next week. September 23d the hgb. was 41 per cent. September 27th she was discharged unrelieved.

Came to the *Out-Patient Department* December 19th for intense jaundice and tenderness over the right lower quadrant. The liver was below the costal margin. Secondary anemia; whitish-yellow discharge.

January 5th she entered the wards for relief of jaundice.

Additional P. H. During the past year and a half she had had three attacks of sharp

precordial pain each lasting about five minutes, coming on suddenly, usually associated with exertion, usually when she was tired and standing. Since her treatment the previous September cta. had been more normal in duration and amount. Had had three radium treatments, the last one about six weeks ago. Weight 128.

P. I. Two weeks before admission, while feeling very well, she noticed yellowness of mouth and eyes. Two days later noticed dull aching pain in the epigastrium and slight chills. The pain gradually worked down to the left lower quadrant. Relieved by hot water bottles. Lately had noticed her urine had become darker, and had stayed in bed most of the time. Yellowness of skin and weakness increased. Three days ago the pain radiated to the left loin and hip. She had continued to have loose movements and chilly feelings. For the past few nights sleep disturbed. Felt exhausted.

P. E. (As before except as noted.) Whole body showed intense greenish-yellow tinge. Mucosæ pale. Scleræ yellow. Marked yellowness under tongue and on palate. Submaxillary glands noted. Heart action slightly rapid. P_2 slightly accentuated. Systolic murmur all over precordia, loudest at second left interspace, where it was rough. Pulse fair volume and tension. Systolic *B. P.* 105, diastolic 60. Artery walls slightly palpable. *Abdomen* full, resistant and tympanitic. Slight tenderness in left lower quadrant. General impression of fluid, but no shifting dullness or fluid wave. Liver dullness 5th rib to 3 cm. below costal margin. Edge felt. Edge of hard spleen felt 1 cm. below costal margin. *Extremities*: some edema of ankles and feet.

Until January 25th *T.* 97.6° - 100.6° , *P.* 80-116. *R.* 11-27. Systolic *B. P.* 110-120, diastolic 50-70. *Urine*: $\bar{5}$ 10-102. Sp. gr. 1008-1012. Cloudy at 2 of 5 examinations. Slight to a very slight trace of albumin at 3. Bile at all, twice in large amounts. Hyalin and granular casts at 3. Occasional leucocytes at 3. *Renal function* 40 per cent. *Blood*: Hgb. 23 per cent to 45 per cent Sahli, 37 per cent

Palmer. Leucocytes 6,200. Polynuclears 65 per cent. Reds 2,552,000-2,866,000. Showed marked achromia, aniso- and poikilocytosis. Many skiocytes. Very few polychromatophilic cells. Platelets increased. *Reticulated reds* 2/10 of 1 per cent. *Bleeding time* one minute twenty seconds. *Coagulation time* 13 minutes. *Calcium in vitro* seventeen minutes thirty seconds. *Blood calcium* 5.6 mgm. *Fragility test January 8th*: Hemolysis began at .50, full at .30-.28, complete at .22. *January 16th*: Began at .46, full at .28, ended at .18. (In normal blood begins at .42, ends at .30 or .28.) "Indicates slight tendency to increased hemolysis, although the fact that so many cells were remaining in the twenties is unusual, and I hardly know how to interpret it." (Dr. A. V. Bock.) *Wassermann* negative. *Stools*: Guaiac negative. Bile positive at three of four tests. *Gastric analysis. Fast-ing contents*: 35 c.c. slightly cloudy straw-colored fluid. No free HCL. Guaiac positive. Many leucocytes. *Test meal*: 25 c.c. cloudy pale fluid. No free HCL. Guaiac negative. *Wolff-Junghans test** of fasting contents positive up to 1:200 dilution. (Positive reaction.) *X-rays. Gall-bladder*: No definite evidence of stone. *Barium meal*. Pyloric end of stomach considerably to the right of the normal position. No definite irregularities of filling or outline. Sphincter and first portion of duodenum appeared normal except for oblique position of the latter. Barium just entering the cecum in six hours and in rectum in twenty-four hours. *Ascitis fluid*. January 22: 2300 c.c. clear light yellow fluid. Sp. gr. 1006. Cell count 94. Smear: a few endothelial cells remained, small lymphocytes. Chlorides 14.72 grams (total). Albumin 0.75 per cent. Culture negative. Bile positive.

The patient was given a fat free diet; bismuth subgallate 5 i t. i d.; aspirin gr. xv; chlorate of soda and potash gargle; benzoin inhalations; a cough mixture of codein, potassium citrate, and syrup of hydriodic

acid; and beginning January 23th KI. She had obstinate distension and grew weaker. After the abdominal tap a mass was palpable in the left lower quadrant. She became very drowsy, weak, and intensely jaundiced. The temperature was 100.2°-102°, the pulse 100-120. No history of diarsenol or other arsenical drugs could be obtained. January 27th she died.

CASE 6211.

Notes on the Record.

Her first husband died of aneurism, that is of syphilis. In the family history, then, there are three different possibilities which ought to affect us; arteriosclerosis, tuberculosis, and syphilis. We hold these in our minds as possible clues to hitch up with something that comes later.

From the account of the blood at the first entry one would say that she had had a typical secondary anemia. That was about eighteen months ago. By the following October, in spite of flowing, the hemoglobin had gone up to seventy-five per cent. In July it was down to ten per cent which should mean a secondary anemia still if correct, because that is lower even than the red count.

Palmer's method generally reads high. It would not be contradictory to our former readings.

In the first entry I should say we have a secondary anemia from menorrhagia. I do not think we have any good evidence of anything more, although there was evidence of something suggesting trouble in the kidney on the left side.

At the Huntington Hospital they treat tumors with radium. Presumably, then, this was a tumor of the uterus, quite possibly a fibroid of the uterus. Nothing has been said to lead us to suppose cancer. My guess is that they said, "Here is a woman very weak from secondary anemia from fibroid of the uterus. That is best treated by radium." And so she went to the Huntington Hospital.

DR. YOUNG: They may have used the X-ray simply to lessen the flowing, regardless of whether there was tumor or not.

*Found positive in gastric cancer (80%) and in a variety of other diseases. Of slight value.

DR. FITZ: The Wolff-Junghans test is for the presence of protein. They test the fasting contents in varying dilutions, and they say that in these high dilutions, if positive, it suggests malignant disease.

Differential Diagnosis.

DR. CABOT: I call that a pretty difficult case. We are confronted with the problem of the cause of the jaundice. Whether that had any direct relation to her previous history of flowing and anemia, I do not know, but I doubt it. It seems as if she began to improve as soon as they stopped the flowing.

What are the definite data? In the first place, jaundice lasting nearly three months, pain of the gall-bladder type so far as I remember, with ascites — a fairly large amount of ascites, the fluid having a low gravity such as we often get with cirrhosis of the liver, rather lower than we should expect with malignant disease of the abdomen. Then there is a mass in the left lower quadrant about which we do not know much. Towards the end she has fever. She has well marked secondary anemia, and that is all that I see.

Now in relation to that mass in the left side. Back in the earlier history she had a dull pain in the left flank on urination, with questionable radiation to the leg, and later pain radiating to the left loin and hip, with a palpable spleen and some enlargement of the liver. With the history of syphilis we are more than usually inclined to think of cirrhosis of the liver. Syphilis is fully as good a cause as alcohol, some people think more important than alcohol as a cause of cirrhosis. That would account for an enlarged spleen. It is very often enlarged in syphilitic or other types of cirrhosis. It would account for the fluid in the abdomen and for the jaundice as part of cirrhosis. Nothing that I see accounts for that mass in the left side, unless we are to suppose some other diagnosis, malignant disease of some kind with metastases in the liver or elsewhere. Those are the two things: cirrhosis of the liver or a malignant mass, perhaps somewhere in the pelvis, perhaps associated with the ovary, with metastases.

Now I should like to ask Dr. Young about the urinary symptoms, the pain in relation to micturition.

DR. YOUNG: I do not think one could say a great deal about that, because she had a cystocele which would interfere with the micturition and is generally accompanied by a little trigonitis. I do not believe we can put anything there unless we assume that she did have a tumor which might have made pressure on the ureter or on the bladder.

A PHYSICIAN: I should like to ask if there would have been a negative Wassermann if the patient had syphilis?

DR. CABOT: Yes. I do not think a negative Wassermann is ever at all conclusive evidence against syphilis, especially late syphilis, as we should naturally think this to be.

DR. YOUNG: How would a solid tumor of the ovary fit this case, when we first saw her causing excessive bleeding—that is accompanied by ascites in a great many cases—and later metastases to the liver and jaundice?

DR. CABOT: They never made any very satisfactory pelvic examination until late in the case, after tapping. One would say they ought to have been able to feel a solid tumor of the ovary, and if they had suspicions anesthetize her or at any rate put her in a hot bath to relax the abdominal walls. The case was in hands of competent people, and we have reason to believe that everything was done that ought to have been done, and therefore probably there was not any hard tumor of the ovary there at the beginning. Dr. Young's chain of reasoning however is one that I cannot answer. It perfectly well could be that. The only point against it is the gravity of the fluid. That is lower than it ought to be. But there are exceptions to that and every other rule. How are you guessing on this, Dr. Fitz?

DR. FITZ: I am guessing on malignant disease. What I am wondering is why they do not emphasize the blood work, try to find out whether she had a simple anemia due to bleeding plus malignancy, or whether it was due to metastases in the bone marrow itself,

and what effect the jaundice had upon such an anemia and bleeding. Apparently they were quite interested in it. I imagine the calcium in vitro test means that somebody thought the jaundice associated with the low blood count, so what they did was to take blood and add calcium and find it did not shorten the coagulation time, but if anything increased it.

A PHYSICIAN: What are skiocytes?

DR. CABOT: Skiocytes are shadow cells, cells where very little of the cells, perhaps just the rim, is seen. They do not mean anything special.

DR. FITZ: Do you talk about nucleated cells still?

DR. CABOT: Yes. I feel pretty clear about the blood. It is a secondary anemia with no evidence of bone metastases. But I do not feel clear about the two diagnoses I have been considering, of cirrhosis or malignant disease. Nothing more is said about the mass they felt after tapping.

DR. YOUNG: Might I add a criticism? It seems to me with that amount of bleeding they have not definitely ruled out a cause, and a curettage would have been in order to rule out malignant disease of the fundus, and when she was under ether to rule out any change in the ovary.

DR. CABOT: I am in doubt, but on the whole it seems to me more like malignant disease. In the first place cirrhosis does not often cause jaundice and very rarely intense jaundice. This was intense jaundice, and got more so at the end. If malignant disease, our best guess, I should say, was that it started in the pelvis, very possibly in the ovary. The metastases that we have definite clues to are at the hilus of the liver and not elsewhere that I see. There is no evidence of anything in the bones or the chest. I do not believe there is anything in the stomach. They thought of gastric cancer. I do not believe there is anything there. There are evidences of adhesions. It seems as if the stomach was pulled over towards the gall-bladder by old adhesions, or possibly by a tumor mass.

A PHYSICIAN: You say you are positive that this is a secondary anemia. How do you rule out primary anemia?

DR. CABOT: The essential thing in the distinction is the question of the amount of hemoglobin per cell. In pernicious anemia there is more hemoglobin per cell than there ought to be. In the secondary type there is less.

A PHYSICIAN: Does that always follow?

DR. CABOT: I do not know any exceptions to it. The only question is the way of getting evidence about that thing. We get it by comparing the hemoglobin with the count of reds (color index). We get it again by studying the stained smear, which is much more reliable. Achromia seen by a man who knows blood at all is as certain as anything I know of as evidence of secondary anemia. But all the other points here fit perfectly well. There is nothing that points at all towards primary anemia as I see it. Never do we see that achromia, that I know of, in primary anemia.

A SURGEON: Does malignant disease of the pelvis tend to metastasize as rapidly in the liver as in other places?

DR. CABOT: She might easily have metastases in other places without our knowing it. We do not in any way rule out retroperitoneal glands if she has malignant disease of the pelvis, but we do not get our fingers on these. Metastases come to light in particular places, in the brain or in the liver. The brain and the liver are the earliest places that show up. We can have metastases in the lung and nobody a bit the wiser, and so with most of the glandular metastases.

A PHYSICIAN: How do you account for the attacks of sharp precordial pain?

DR. CABOT: I do not account for them. I do not believe she has either syphilitic aortitis or arteriosclerosis enough to give definite angina. I have seen attacks like that in pernicious anemia, I suppose due to the fact that the heart could not get enough blood through the coronaries, but I cannot remember that I have ever seen it in secondary anemia. Still I do not see why it should not

come in secondary as well as in primary. So that if it is accounted for by anything that I have spoken of it would be in that way.

Clinical Diagnosis (from Hospital Record).

Hypostatic pneumonia.

Malignancy of pancreas?

Secondary anemia.

Dr. Richard C. Cabot's Diagnosis.

Malignant disease of the ovary with metastases in the liver.

Secondary anemia.

Anatomical Diagnosis.

1. Primary fatal lesion.

Acute yellow atrophy of the liver.

2. Secondary or terminal lesions.

Icterus.

Hemorrhage into the abdominal muscles.

Hemorrhagic areas in the pericardium.

Soft hyperplastic spleen.

Ascites.

Edema of feet and ankles.

Edema piæ.

Septicemia, streptococcus.

3. Historical landmarks.

Slight hypertrophy and dilatation of the heart.

Myosarcoma of the uterus.

DR. RICHARDSON: We have a complete examination in this case.

Head: The pupils dilated and equal. The pia showed a little edema, the brain tissue was a little wet and bile-stained. The conjunctivæ were bile-stained. The skin generally showed a marked icterus. The umbilicus pouted slightly. On opening the peritoneal cavity at least 2000 c.c. of thin, pale, clear golden fluid was found. The uterus was moderately enlarged, and in its wall a fibromyoma three inches in diameter rounding up under the endometrium, where it was very vascular and might very well be the source of the bleeding. The condition of the fibromyoma at this time is of interest because it had been exposed to radium. The only difference between the ordinary fibromyoma, not exposed, and this one was that this was a little softer and paler. The adnexa were negative. The esophagus, stomach and intes-

tinal tract were negative except that they were generally bile-stained.

The description of the liver is a short account and as nearly classical as I can make it. It weighed 1340 grams, a little small, but not markedly so. It was at the costal border. Did they mention more than once where the margin of the liver was?

DR. CABOT: No.

DR. RICHARDSON: The right lobe rounded up into a roughly spherical mass and the left lobe was much reduced in size—about one-half. The capsule was generally smooth, but toward the peripheral portions of the lobes was dull reddish and showed faint wrinkling. The liver tissue over a large area bulged up beneath the capsule giving a markedly yellowish mottled appearance which faded out towards the peripheral portions of the lobes. On section the tissue over large areas was yellowish mottled with a faint reddish mottling in places, and the cut surfaces rounded up markedly with rolling back of the capsule. The tissue was pulpy, and quite soft even to slight mushiness. Toward the peripheral portions tissue of the character described gave place to a smoother, firmer, dull reddish to grayish red, slightly leathery tissue. The capsule seemed to be slightly thickened in places. The portal spaces in the section surfaces rested deep down in the pulpy tissue.

Diagnosis, atrophic degeneration of the liver (acute yellow atrophy).

A PHYSICIAN: What was the mass on the left side?

DR. CABOT: I guess it was that fibroid of the uterus. Of course there was hypertrophy of the spleen, and it might be a source of pain on that side.

DR. RICHARDSON: An interesting thing in this case was an appearance similar to what occurs in influenza. There was an area of hemorrhage in the abdominal muscles and some hemorrhagic areas in the epicardium. Those of course were expressions of toxemia. There was a terminal streptococcus septicemia, which is also a feature in many cases of "influenza pneumonia."

A PHYSICIAN: Did you say the cause of all the anemia and of all this toxemia was discovered? Why was she anemic?

DR. RICHARDSON: So far as the anatomy goes, the fibromyoma was a distinct source for secondary anemia. It is very well known that profound anemia can be produced by fibromyoma no bigger than the thumb. When she was hit by that intense toxic substance which produced the atrophic condition of the liver I do not know.

DR. CABOT: I would call attention once more to the extraordinary number of cases of acute yellow atrophy this year—entirely unequalled in my experience.

DR. RICHARDSON: There is another point of interest. This case was associated with radium therapy, some of the cases with arsenical therapy.

DR. CABOT: What is your guess about the number of cases this year?

DR. RICHARDSON: We must have had four here.

DR. CABOT: And I have seen more at the Brigham Hospital. One often goes through a number of years without seeing one. There is no question that there are more cases of this type than ever before, whether or not it is due to the increased use of arsenic for syphilis or of radium for tumors and other purposes. Here is a disease that most men used to live and die and never see, and I have seen seven or eight cases this year. In twenty-three years at the John Hopkins Hospital they had only three cases.

A PHYSICIAN: How can one make the diagnosis?

DR. CABOT: When we have made it right, wholly by the exclusion of other causes of jaundice. There was no evidence of malignant disease or stone or cirrhosis, and the person very quickly went down. The acuteness of the course has helped us several times. This was not acute.

The ascites was notable. It was present in another of our cases of acute yellow atrophy (Necropsy 2084, published as Case 333, August 14, 1917). Rolleston in his classic work on Diseases of the Liver: "A slight

amount of ascitis fluid in the peritoneum is not uncommon." In the present case and in Necropsy 2084 the ascites was abundant. Osler does not mention it at all. I suppose it is due to portal obstruction.

NEW AND NONOFFICIAL REMEDIES.

MERCUROCHROME-220. — A preliminary report of the Council on Pharmacy and Chemistry discusses the experimental status of this new germicide for use in the genito-urinary tract. While the lack of confirmatory evidence of its value does not permit more than a tentative acceptance, the available data may be sufficient to warrant its use by physicians, provided its experimental therapeutic status is recognized. Mercurochrome-220 (marketed by Hynson, Westcott and Dunning, Baltimore) is stated to be dibromo-oxymercury fluorescein. It is a red powder, insoluble in water but soluble in alkalis. According to Young, White and Swartz, Mercurochrome-220 is a strong and rapidly-acting germicide which penetrates the tissues readily and is tolerated in 1 per cent solutions by the bladder, renal pelvis and urethra. Only temporary discomfort is caused when a 2.5 per cent solution is applied to the anterior urethra. Its toxicity is high, but no systemic effects have been observed following its local application. (*Jour. A. M. A.*, January 3, 1920, p. 31.)

PASTEUR ANTI-RABIC VACCINE (GILLILAND). — An anti-rabic vaccine (see New and Nonofficial Remedies, 1920, p. 272) prepared according to the method of the U. S. Public Health Service. The treatment consists of twenty-one to twenty-four doses and these are sent separately each day by special delivery. The Gilliland Laboratories, Ambler, Pa.

PNEUMOCOCCUS VACCINE IMMUNIZING (GILLILAND). — A pneumococcus vaccine (see New and Nonofficial Remedies, 1920, p. 286) containing Types I, II and III, respectively, in equal proportions. Marketed in packages of four 1 c.c. syringes and also in

packages of four 1 c.c. ampules, containing 250, 500, 1,000 and 2,000 million killed pneumococci per c.c. The Gilliland Laboratories, Ambler, Pa.

PROCAINE-CALCO. — A brand of procaine complying with the N. N. R. standards. For a discussion of the actions and uses of procaine, see New and Nonofficial Remedies, 1919, p. 30. The Calco Chemical Company, Boundbrook, N. J.

TYPHOID-PARATYPHOID BACTERIN (Special Bacterial Vaccine No. 13).—Marketed in 5 cc. vials, each cubic centimeter containing 1,000 million killed *B. typhosus*, 750 million killed *B. paratyphosus* "A" and 750 million killed *B. paratyphosus* "B." For a discussion of typhoid vaccine, see New and Nonofficial Remedies, 1919, p. 292. E. R. Squibb and Sons, New York. (*Jour. A. M. A.*, January 3, 1920, p. 31.)

ANTISTREPTOCOCCIC SERUM-GILLILAND.—The serum of horses which have been immunized with virulent strains of hemolytic streptococci. Each package bears the statement "No U. S. Standard of Potency." Marketed in 10 c.c. syringes, 20 c.c. injecting packages and 50 c.c. injecting packages. Dose: 10 to 200 c.c. (see New and Nonofficial Remedies, 1919, p. 272). Gilliland Laboratories, Ambler, Pa. (*Jour. A. M. A.*, October 25, 1919, p. 1287.)

BACILLUS BULGARICUS-SQUIBB.—A culture in vials of the *Bacillus bulgaricus* type A, the *Bacillus bulgaricus* type B (*Bacillus*

acidophilus) and the *Bacillus paralacticus*, each vial containing 12 c.c. The preparation is designed for internal administration and for topical application (see general article, Lactic Acid-Producing Organisms and Preparations, New and Nonofficial Remedies, 1920, p. 156). E. R. Squibb & Sons, New York.

POLLEN ANTIGEN-LEDERLE (SPRING TYPE). — A liquid obtained by extracting equal parts by weight of dried pollens of timothy, red top, June grass, orchard grass, sweet vernal grass, meadow foxtail, meadow fescue, rye and wheat by a vehicle of 67 per cent glycerine and 33 per cent saturated solution of sodium chloride. Each c.c. contains 14,000 pollen units (a pollen unit is the equivalent of 0.001 mg. of pollen). For a discussion of the actions, uses and dosage, see Pollen Extract Preparations, New and Nonofficial Remedies, 1920, p. 236. The product is supplied in fifteen different doses, each dose consisting of 0.1 c.c. of the respective dilution. Each dose is accompanied by a vial containing 9 c.c. of sterile water for diluting the dose to make it of isotonic strength. Pollen Antigen-Lederle (Spring Type) is supplied in packages containing a complete set of fifteen doses, in packages containing sets of five doses and as a diagnostic test consisting of 0.01 c.c. of No. 15 dilution. Lederle Antitoxin Laboratories, New York. (*Jour. A. M. A.*, April 24, 1920, p. 1167.)

PUBLISHER'S NOTES

CASCARA IN CONSTIPATION.

There is a distinct advantage in using cascara sagrada in the treatment of chronic constipation. For example, cascara stimulates the muscular structure of the intestine, thus promoting normal peristalsis. It activates the intestinal follicles, thus augmenting glandular secretion. Moreover, this stimulating effect is mild, not excessive. It approximates the work of Nature and is therefore not harmful or reactionary.

To state the case in another way, cascara unloads the bowel in a normal manner and not by exciting violent and painful peristaltic movements and tenesmus, such as not infrequently attend the use of the conventional purgative.

No other drug replaces cascara sagrada, which alone can be given for long periods without detrimental effect. In fact, success in its use depends upon its continued admin-

istration, in gradually ascending doses, until a natural daily action has become the fixed habit.

The original bitter fluid extract of cascara, introduced by Parke, Davis & Co., in 1877, is the preferred preparation in most cases, because of its well-known bitter-tonic effect. It is given in doses of 5 to 30 drops, according to the condition to be met, and this dose may be continued for several weeks in chronic cases. In more obstinate cases the

initial dose should be increased gradually until the desired result is attained. At this point a progressive tapering-off system of dosage is adopted, rather than an abrupt cessation of the treatment.

The bitter fluid extract of cascara is readily taken in gelatin capsules, which may be supplied to the patient with a medicine dropper. The prescribed dose is dropped into the capsule, which is then closed and swallowed with no suggestion of its contents.

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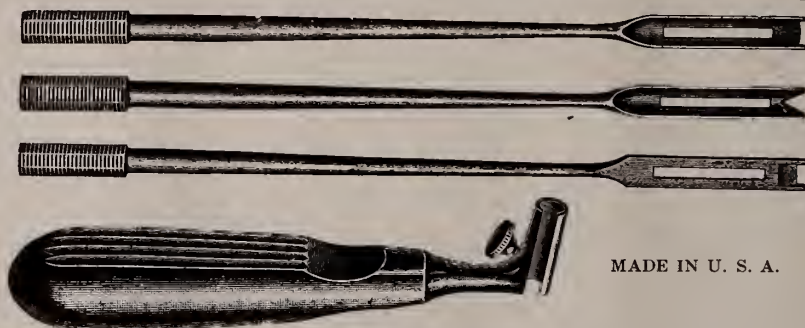
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ORIGINAL ARTICLES

OBSERVATIONS ON SOME OF THE COMMON SURGICAL CONDI- TIONS OF THE KNEE.*

EDWARD JELKS, M. D.,
Jacksonville, Fla.

Because we often fail to consider the anatomy of the knee and its associated pathology, our profession is allowing many patients to live and work with knee joints that are only partially performing their function.

The knee joint is composed essentially of the articular surface of the femur and tibia surrounded by a capsule. This capsule is thickened in places and is augmented in places by ligaments. It has an endothelial synovial lining. Without the capsule, at various points of pressure by tendons, there are bursæ. It is our purpose in this paper to discuss some of the surgical conditions of the structures without and within the capsule, and of the capsule itself.

It is often difficult to determine what structure is at fault and giving symptoms, because injury or infection of the parts within and without the joint give symptoms which are very much alike. There is usually pain and swelling. The synovial membrane is extremely sensitive and produces fluid within the joint from very slight irritations. This may occur in strain of the external ligaments, pressure by enlarged bursæ, trauma to the capsule itself, rupture of the crucial ligaments, dislocation of the semiluna cartilages, pinching of the capsule between the articular surfaces of the femur and tibia, and infection of the synovial membrane of the membrane

of the capsule. A most helpful guide towards diagnosis is the history. The point of maximum tenderness will often differentiate between a ruptured cartilage and an irritated bursa.

A good general rule to follow, is, that infection within the joint or arthritis gives pain on every movement of the knee, while localized pathological conditions give pain only on specific movements of the knee.

Housemaid's Knee is well known by the laity. This condition, an inflammation or irritation of the prepatellar bursa, though the most frequent bursitis of the knee, is by no means the most disabling. High up under the quadriceps tendon lies the largest bursa which, while developing separately from the joint cavity, very early in childhood communicates with the joint cavity, thus increasing the extent to which the infection may reach in synovitis. Knowledge of this anatomical fact is essential in adopting any method which is employed to drain the knee joint. The bursa under the patella tendon at its insertion on the tibia, the infrapatella bursa, is often the seat of irritation causing disability. It has not been many months since I had this impressed upon me. The patient was a soldier, thirty-five years old, who was sent into the hospital because of limp, pain, and swelling of the knee. The diagnosis upon admission to the hospital was "hernia through the joint capsule." The history revealed that for five or six months there had been times when there was pain just below the patella tendon when the patient flexed or extended the knee. This symptom would become less severe after a few days of fixation of the joint. Distention of the joint, with fluid, was always present with the periods of pain. On examination, it was found that

*Read before the forty-seventh annual meeting of the Florida Medical Association, at Daytona, May 12, 13, 1920.

sudden flexion or extension of the knee caused pain under the patella tendon. The leg could be fixed and extended through an arc of about eighty degrees. There was a small amount of fluid in the joint. The thing which had suggested a hernia of the joint was a bulging from under the outer side of patella tendon when the knee was flexed. Especially noticeable was this when the knee was flexed beyond forty-five degrees. There was then present a soft round mass about three-fourths of an inch in diameter. This disappeared almost completely when the joint was relaxed. After a week of complete rest to the knee, the fluid disappeared, but the swelling under the patella tendon remained unchanged. Through an elliptical incision, there was found beneath the tendon a markedly enlarged bursa pressing on the capsule. The bursa was excised and the wound closed without drainage. In two weeks the patient was walking without pain. After four weeks there was no swelling, no pain. Function of the knee was normal. Besides these bursæ already considered, there are similar ones; as that between the long lateral ligament and the tendon of the popliteus muscle, that between the ligament and the tendon of the biceps. Any one of these may become irritated and give trouble. Infection within them may extend into the joint.

Within the joint the semiluna cartilages and crucial ligaments are most liable to be seats of pathological changes. They are the results of trauma causing rupture of the ligaments or dislocation of the cartilages. Operative treatment of ruptured ligaments is seldom indicated and suture of them has been successful in only rare instances. Quite the opposite is true with ruptured or dislocated cartilages. There are very few conditions which respond more satisfactorily to surgical therapy than removal of torn, dislocated cartilages.

The following is a good example of the continued disability to a patient caused by injury to a semiluna cartilage:

The patient (F. S. C.), aged fifty-three, states that when ten years old, he slipped on

the ice and injured both knees. For a long while after there was a feeling of weakness as though the "knees were out of joint." This, however, did not interfere with the activities of boyhood and early adult life. Eleven years ago while turning in bed a very severe pain suddenly appeared in the right knee and the joint became locked. For four months after this he walked with the aid of crutches and a stick. The knee was apparently normal until five years ago, when it again locked while he was turning in bed. Two years later in January, 1917, the same accident occurred again. I saw him three months after this. During these months he had not been able to return to his former work. He was walking with the aid of a cane. The pain was then well localized on the outer side of the knee just over the external semiluna cartilage, and at this point there was exquisite tenderness on pressure. Since the external cartilage is at fault in only about 3 per cent of the cartilage injuries, we were very careful to make sure of the diagnosis before advising operation. With a history of repeated locking of the knee, followed by a rather extended period of disability and pain over the external cartilage, we concluded that the external cartilage was causing the patient his trouble. So on March 31, 1917, we opened the right knee joint. There was found an external cartilage which had been fractured across the center. The loose anterior fragment was slightly reddened and the peripheral portion was thickened. At its juncture with the capsule there was unusual hypertrophy. The cartilage was excised, and the patient was up on crutches in two weeks. Four weeks after the operation he was walking without the use of a cane, and in eight weeks he had returned to his normal work. He has had absolutely no trouble since this time, and reports that he is able to do much more strenuous work than was possible a long while before the operation.

The question of suppurative arthritis, pus in the joint, has aroused keen interest with-

in our profession during the recent war. Before the experience which the war gave, the results from treatment of purulent arthritis of the knee had been almost universally unsatisfactory. To rid the patient of infection, even though there were marked limitations of function, had been generally considered a good result. But now under the leadership of the Belgian surgeon, Willems, we have grown to be dissatisfied with a result short of free motion of the joint.

Once the diagnosis of the suppurative arthritis is made by aspiration and laboratory examination, which will reveal pus cells and bacteria, the accepted treatment is as follows:

1. Make on either side of the joint a lateral incision extending from the top of the tibia upward, high enough to open thoroughly the joint cavity under the quadriceps. In the adult these incisions will be four or five inches long.

2. Do not put in drainage, as it causes adhesions and interferes with the subsequent treatment, that of mobility.

3. This treatment begins with early active motion of the joint. When the patient awakes from anæsthesia, he is urged to flex and extend the knee. This is repeated at two-hour intervals day and night for about a week and is continued every two hours during the day for a week longer. At the end of this time the patient can usually begin to walk on crutches, his temperature returns to normal in four to six days and remains normal.

When treatment consisting of incision, fixation, and the insertion of tube or gauze drainage is adopted, the liability of pocketing of pus within the posterior pouch and under the quadriceps tendon is extremely great, and extension of the purulent process from the joint may result in an osteomyelitis. How often have I seen multiple operation scars and sinuses around knee joints which had been operated upon weeks before and still the patient was having fever as a result of inadequate drainage of the joint; inadequate drainage consisting of incision, fixation, and drainage tubes.

Illustrative of the method and result of the Willems treatment, I would like to present the following case:

Patient (J. F. M.), a soldier, age twenty-two years, Base Hospital Camp Grant. On May 9, 1919, following a skinflap operation to close an old osteomyelitis of the tibia, the patient's knee became the seat of a metastatic purulent arthritis which was characterized, six days after the operation, by a temperature of 105 degrees, a leukocytosis of 21,000, and a swollen, painful knee. The aspirated fluid contained many pus cells and small cocci arranged in chains. Without waiting for a cultural differentiation of the organism, the patient was operated upon. An incision was made on either side of the capsule extending from the head of the tibia sufficiently high to include the farthest extent of the joint cavity. The pus was sponged from the wound, vaseline was spread around the wound and a dry dressing was applied. Active motion was begun two hours after the patient waked from anæsthesia and continued every two hours day and night. The following day the patient could flex the knee to forty degrees. Six days after operation his temperature was normal and he could flex his knee to ninety degrees. Eighteen days after operation, the patient was walking with a cane. He had complete extension of the leg and flexion to 110 degrees.

CONCLUSIONS.

1. Careful study of the pathological anatomy of the knee joint will often reveal conditions around and within the joint which are causing chronic disability of its function. Many of these conditions can be relieved by simple surgical treatment.

2. To obtain the maximum ultimate function of the knee in purulent arthritis, the best treatment is that of Willems, consisting of adequate incision and the introduction of early, active motion; omitting the employment of any sort of drainage tube.

SUGGESTED IMPROVEMENTS IN CARING FOR MENTAL CASES PRIOR TO ADMISSION TO STATE HOSPITAL.

W. M. BEVIS, M. D.,

*Assistant Physician, Florida State Hospital,
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There are some clearly indicated improvements in connection with the care and treatment of mental and nervous cases prior to their admission to the Florida State Hospital that should have the attention of the medical profession of our state.

(1) At present a majority of cases admitted to the State Hospital are kept in jail from the time judicial inquiry as to their sanity is begun until the attendant nurse, as the agent of the State Hospital, receives them at some point in the patient's home county. Reference to the records of one hundred successive admissions of white males shows that fifty-four of this number were in county jails when received for transportation to the State Hospital, and that forty-four of the fifty-four came from counties whose citizens are proud of their well-equipped city or county hospitals.

If a destitute citizen is found sick of pellagra, typhoid fever or Bright's disease, the city or county immediately provides adequate medical attention and hospital treatment, but if a patient develops a psychosis as a complication to these or other such diseases in three or six months, he is taken to jail until transferred to Chattahoochee. This discrimination against mental and nervous cases, the most unfortunate of all forms of illness, should not be permitted. Even if this practice did not seem so inhumane and out of date, the fact that the psychoses and nervousness of patients are made worse by the experience of three or four days in a jail should condemn it. Multiplied instances can be cited in which the impression (on account of their jail experience) that they had committed some crime was the last to be dissipated from the mind of the patient as they come again from the mists into the bright sunlight of restored

understanding. Some grow chronic with the memory of their stay in jail foremost in their ideas of persecution and ever present in their fears and obsessions. The county officials are in no wise responsible nor to blame for this condition. They are doing their duty just as it has been done by their predecessors for the last twenty-five years. It is not within their power to change this custom even if they desired. The law needs to be amended to regulate this point. When the public is informed and this condition is seen to be unfair and harmful to the patient, the necessary legislation to correct it will speedily be enacted. Medical men, woman's clubs and those interested in improving social conditions can help bring this about. In addition to giving the legal authority to the county, all that is needed to obviate this obsolete custom is the altering and rearrangement of two or three rooms at some hospital designated by the county commissioners to meet the needs of this particular class of patients, so that all persons not under indictment for crime committed who are insane or suspected of being insane may receive hospital care in their own county until such time as they are received by the state for treatment.

(2) Early hospital treatment of mental cases offers the most hope for recovery. All forms of mental alienation untreated tend to become chronic and more hopeless and few recover after eighteen months or two years. Even though this is generally understood by the physicians of the state and many of its citizens, we see many that have already become chronic by indifferent waiting with the apparent notion that since the patient can express his likes and dislikes and is not a raving maniac the mental unbalance might right itself. Much emphasis upon the part of the physicians should be placed upon this point in instructing relatives of patients having even a slight psychosis. All cases should have prompt treatment in a private or state hospital. This plan will save to our state the burden of many hopeless cases and will restore to homes and useful occupations many good citizens.

(3) Too great a number of senile cases are brought to the State Hospital having chronic or incurable diseases that render them helpless and harmless. They usually die from the disease or the shock of the trip within the first few days or weeks after admission. The law is plain governing such cases and provides for their proper care by relatives or by the county as charity cases.

The hospital records of the one hundred successive admissions first mentioned show that eleven died within sixty days. The age of these eleven cases and the number of days each lived after admission is tabulated below :

Age of each patient in years:												
53	60	64	65	66	66	67	69	70	72	73		
Days lived after admission:												
9	4	25	10	9	24	13	39	9	57	59		
Average age, 66; average days lived after admission, 23½.												

The examining physicians and the county authorities can assist in correcting this, and we believe they will when they see that such a policy if perpetuated will show up their county unfairly and is not best for such patients.

Summary. — (a) A majority of cases admitted to the State Hospital are kept in county jails from time judicial inquiry is begun until the agent of the Hospital arrives. Records, white male admissions, show 54 per cent received from jails, 44 per cent from counties having good hospital facilities. This practice is out of date and aggravates all psychoses. Physicians of the state can be of service in correcting this and assist the county commissioners in making provision for giving such cases correct hospital care in home county until transferred to the State Hospital.

(b) Members of the profession should urge the relatives of all patients having even a slight psychosis to give them hospital treatment early after onset to avoid possibility of condition becoming chronic.

(c) Too great a number of senile, helpless cases are sent to the State Hospital, who die within a short time from their chronic diseases or effects of trip. Should be treated

as charity cases in home city or county. Eleven per cent of admissions have average age of 66 years and live average of 23½ days after arrival.

The fact that public opinion and precedent have given sanction to these things is no excuse for their continuation.

SOME REMARKS ON THE DIAGNOSIS OF CHRONIC GASTRITIS.

GEORGE M. NILES, PH.G., M.D.,

Gastroenterologist to the Georgia Baptist Hospital and Atlanta Hospital; Consulting Gastroenterologist to the Anti-Tuberculosis Association, Etc., Atlanta, Ga.

Up to the time that more exact methods of examination came into vogue the diagnoses of chronic gastritis, chronic catarrh of the stomach, and chronic dyspepsia were made in those cases of digestive disturbance characterized by long-continued nausea and indigestion, unless the symptoms of ulcer or cancer stood out predominantly.

Since the refinements of diagnosis have enabled gastric diseases to be more intelligently discriminated, this diagnosis is not made so frequently as formerly, though even now about 8 or 10 per cent of chronic indigestions may be placed in this class.

This disease occurs more frequently in men than in women, and the same irritating causes that produce acute gastritis can produce the chronic type when exerted for a long period of time; such as hasty eating with imperfect mastication, gastronomic excesses, highly spiced foods and condiments, over-indulgence in tea, coffee or alcohol, excessive use of tobacco, especially chewing strong, black tobacco, habitual use of certain drugs, and a septic condition of the teeth as pyorrhea alveolaris, in which constant swallowing of pus and other products of decomposition sets up inflammation. Though smoking is ascribed as a cause by some writers, I have never seen a case of chronic gastritis that could be honestly traced to that habit. (Let this not be considered a defense of smoking,

for many forms of neurotic indigestion or even atony may follow in the wake of excessive indulgence in this use of tobacco.) Probably the commonest cause is found in the abuse of alcoholic drinks, though some stomachs seem to bear without injury quantities of alcohol that would acutely inflame others. I have seen a few individuals who suffered from chronic gastritis for two or more weeks after the ingestion of less than four ounces of rye whiskey.

Acute gastritis does not generally merge into the chronic form, except where there are a number of recurrences at short intervals from similar causative factors. It may be secondary to acute infectious diseases, as typhoid fever, and is frequently associated with cancer of the stomach. It may be secondary to cirrhosis of the liver, pulmonary or cardiac disease, and chronic nephritis and syphilis.

There are several forms of chronic gastritis, as follows:

The form in which there is excess acid—acid gastritis, hypersthenic gastritis, or acid catarrh of the stomach.

The form in which, while there is chronic catarrh, there is practically normal acidity.

The form in which there is a diminution or absence of acid, denominated asthenic gastritis or atrophic gastritis.

To this may be added a rather specific form—alcoholic gastritis.

Symptoms of Chronic Gastritis.—These are much like those of other gastric disturbance. The disease, as a rule, develops slowly, changing in its aspect from time to time. The appetite is variable, sometimes being quite good, or even ravenous, then for a time the patient may have absolutely none. A disagreeable taste in the mouth is often mentioned, there is thirst and dryness of the mouth with frequent eructations of ill-smelling gas containing occasional food remnants. Pressure and fulness after eating are complained of, with palpitation of the heart during the digestion of meals. For a while the eructations seem to relieve most of the dis-

treasing symptoms, but as the disease progresses, there is almost constant uneasiness in the epigastric region during waking hours. The sleep, however, is troubled, and the patient often awakes with headache, followed by vertigo on arising. The bowels are usually constipated, with perhaps an occasional attack of diarrhea.

When vomiting occurs, it is usually in the morning, and consists chiefly of slimy mucus, with occasional remnants of the previously ingested food. The tongue is sometimes covered with a thick gray fur, though this is by no means characteristic. Odor of the breath is offensive, especially when there is atony of the stomach with fermentation, or the teeth are in poor condition.

Nearly all of these patients are low-spirited and pessimistic. It appears that the complex of symptoms embraced in chronic catarrhal gastritis exercises a peculiarly depressing effect on the mentality, and seldom have I seen any individual suffering from this disorder who did not feel his spirits dampened and his mental horizon beclouded.

The patient's appearance may be quite good and he may preserve his weight remarkably well. In severe cases he looks bad, shows black rings under his eyes and chills easily. Where the anorexia is prolonged much weight may be lost, and an extremely emaciated state may supervene.

Upon physical examination the epigastrium may appear bloated. Tympanites is sometimes present, but the stomach is usually in the normal position. The gastric region is sensitive to pressure, with rather diffuse tenderness. There is seldom any real sense of resistance or rigidity there.

The urine is generally scanty, with increased specific gravity. It is frequently loaded with phosphates and urates.

Diagnosis.—The diagnosis of chronic catarrh of the stomach *cannot* be positively and intelligently made without the employment of the stomach tube. By gastric analysis many suspected cases prove to have normal gastric contents, and are to be considered

neuroses; while in other cases evident gastric catarrh is discovered when some other condition was thought more probable.

It is advisable that:

(1) Gastric analyses should always be made in every case of dyspepsia, no matter whether these symptoms be apparently gastric or intestinal, unless passage of the tube is contraindicated.

(2) Gastric analyses should always be made in all cases of intestinal toxemia, of recurring headache of toxic origin, and in patients who complain of the symptom-complex which is spoken of by the laity as "biliousness."

(3) Gastric analyses should be made in all cases of anemia and general physical wretchedness without known cause and which are rebellious to treatment.

The presence of *gastric mucus* in *excessive quantities* in the stomach contents is the chief diagnostic point in chronic catarrhal gastritis.

My usual procedure is as follows: One hour after an Ewald-Boas test meal has been taken (two slices of bread without butter and a glass and a half of water), a sufficiency of the stomach contents are aspirated for an examination. In chronic catarrhal gastritis these conditions are usually found present: the total acidity is often diminished; free hydrochloric acid is small in amount, or absent; pepsin and rennin are present but diminished; erythrodextrin present in small quantities; achroodextrin and sugar abundant. Should the gastric contents well up into the tube in great quantity, hypersecretion may be suspected.

The particles of bread are not as fine as normally, but larger and coarser. Mucus is intimately mixed with food remnants and is adherent to the larger particles. Upon passing a wire up through the contents, thick, tenacious ropes of glairy mucus hang to it, presenting a characteristic appearance. Should there appear but little mucus when the symptoms would indicate its presence, the patient should be seen the following morning with an empty stomach, and lavage

performed, in which event, the mucus will easily be discovered in the wash-water.

Microscopically.—Mucus, round cells and epithelial cells are found to be present. In doubtful cases the microscope may enable the physician to differentiate the types of mucus. If squamous epithelium is mixed with it, this probably comes from the mouth or pharynx; if pigmented alveolar epithelia, probably from the air passages. Columnar epithelia, mixed with mucus, shows its gastric origin.

Chemical Findings.—With acid gastritis we find the free hydrochloric and total acidity somewhat or greatly increased, though this reaction bears but little comparative relation to the amount of mucus present. The observant physician may find cases of marked catarrhal gastritis in which the acidity remains practically normal, notwithstanding gastric disturbance, anorexia, and malaise.

In sub-acid gastritis there may appear all gradations from a slightly reduced acidity to a complete absence of gastric juice, or achylia gastritis.

Einhorn has carefully examined the washings of many cases, finding small shreds of the mucosa present, which he believes to be due to erosions.

Motility.—This is generally good in acid cases, in fact the tendency is toward an increased evacuation of the stomach. Should atony or dilatation be present, there is naturally motor insufficiency, and, in the absence of acid, fermentation.

Absorption.—While physiologic absorption in the stomach is but slight, even that small amount is interfered with when the mucosa is coated with thick, glairy mucus.

Course.—The tendency of all chronic gastritis is toward a long duration, and, like some cases of postnasal catarrh, may extend over many years without incapacitating the patient for the ordinary duties of life. Even where there seems to be decided improvement, relapses are frequent, and no one can be considered permanently cured until many months have elapsed without gastric disturbance.

These somewhat brief remarks are based upon considerable experience in these rather indefinite conditions, and I trust that they may be found worth-while to the reader.

AMERICAN COLLEGE OF SURGEONS.

FRANKLIN H. MARTIN, M.D., F.A.C.S.

(Concluded from July Number)

V. MEDICAL SCHOOLS.

We visited medical schools connected with the national universities at Lima, Santiago, Buenos Aires, and Montevideo. A primary, high-school, and university education is required by the medical schools for the admission of students. Peru, Chile, and Argentina require a seven-year course of medicine, while Uruguay requires but six. So far as we could judge them in our cursory visit, the physical properties of each of these four schools were adequate and modern in every detail. Judging from the provision for free hospital beds in so many of the hospitals of the cities in which the schools are situated, which are under the control of the faculties, the clinical material should be abundant. The laws of each of the governments provide for a reasonable distribution of dissecting materials, and postmortems are an accepted requirement. Our opportunity for meeting a strong group of each faculty was most favorable, and if the faculty as a whole approaches in point of ability the members with whom we became acquainted, the faculties are exceptionally strong. While it was vacation time and the medical schools were not operating at full capacity, we had an opportunity of observing and meeting a large number of students and a larger number of recent graduates who were serving as internes in the hospitals, and I am sure we were agreed that in appearance they compared favorably with those of the United States, Canada, and England.

The leaders of the faculties are men who have supplemented their home training by study in France, Germany, or other foreign

countries, while a few have been in the United States. One cannot but realize that these medical schools are built on sound, fundamental bases. However, it was not possible for us in a short visit during the summer vacation season to judge of their present teaching value.

VI. HOSPITALS

The hospitals in South America, not unlike the hospitals in other civilized portions of the world, may be divided into several classes. One of the objects of our trip was to obtain a bird's-eye view of the hospitals in the cities we visited. We passed through, very hurriedly of course, a number of the principal hospitals in each of the capitals, and Valparaíso and a few other cities. With only minor exceptions, they all had suitable buildings and interiors, and opened onto extensive and attractive gardens or patios. Without exception, I believe all of them have a system of case records, and the average of completeness in this respect was above that found in the United States. Everywhere working laboratories, including X-ray outfits, were in evidence and were pointed to with pride. The operating rooms, with but few exceptions, were modern, and contained the most approved sterilizing apparatus. Conveniences for diagnostic purposes, and instruments for operating rooms were in abundance. Nearly all had provision for postmortems, and up-to-date morgues. The provision for graduate internes seemed to be adequate, especially in those hospitals connected with teaching institutions. Nearly all of the large hospitals had rather complete out-door dispensary departments. Some of the hospitals were deficient in modern plumbing. However, a large percentage of the important hospitals were elaborately equipped with these conveniences. Some had the most approved hydrotherapeutic departments, and modern laundries and kitchens were in evidence in nearly all of the larger institutions. The hospitals which did not have the full equipment as enumerated above were not a few, but nearly all of these are in line for a rapid readjustment. Especially is this true

since their teachers are thoroughly alive to the requirements of a modern hospital.

Two defects which were evident in nearly all of the hospitals visited and which appealed to us as rather easy to remedy were the lack of screening against flies, mosquitoes, and other insects, and a well organized system of nursing. The former of these will soon be remedied, and the latter is a difficult problem with which the faculties are wrestling. It was not a defect pointed out by us, but was freely admitted by our hosts.

The Modelo Instituto Clinica in Buenos Aires may well be taken as a model for all hospitals built in a climate such as Argentine's. It is one of the most beautiful from the standpoint of architecture and grounds, and its equipment, as far as we could judge, with the exception of the nursing organization, is complete in every detail. It was built as a model by the government of Argentine, and is maintained as such, which fact evidences the yearning of the people and the profession of this country for the best that can be devised. This hospital is also completely screened.

VII. THE SURGEONS.

Peru. The Sociedad de Cirugia del Peru is of recent origin, and was established along the lines of the successful societies of the United States and Europe. The organizers have had the courage of their convictions, and have carefully selected their members. They have built themselves an attractive home in which to meet, to house their literature, and to entertain the stranger. The membership is limited to surgical specialists, and its members do not yet number twenty.

Nowhere in the world, I am sure, can the modern surgeon find himself more at home than among the surgeons of Peru; they are all men of the highest type; they are educated and possess the culture that comes from travel and study abroad, and they are conversant with at least one language besides their own. Nearly all of them speak French, a large percentage some English, and many of them converse with ease in the English tongue.

When we consider the personnel of these hosts of ours immediately come to mind the following: Dr. Miguel C. Aljovin, surgeon of the Maison de Santé, honorary member of the Faculty of Medicine; Dr. Constantino J. Carvallo, professor of descriptive anatomy; Dr. Juvenal Denegri, professor of otology, rhinology and laryngology, surgeon to Santa Ana Hospital; Dr. Guillermo Gastaneta, professor of clinical surgery, surgeon to Dos de Mayo Hospital; Dr. Francisco Grana, professor of surgical pathology, surgeon to Guadalupe Hospital; Dr. Carlos Morales Macedo, professor of applied anatomy, surgeon to Guadalupe Hospital; Dr. Carlos Villarán, professor of clinical surgery, and surgeon to Military Hospital; Dr. Mariano Alcedan; Dr. Constantino T. Carvallo, professor of gynecology; Dr. Manuel J. Costaneda, surgeon to Italian Hospital; Dr. Enrique Febrea Odriozola, professor of obstetrics; Dr. Juan J. Mostajo, surgeon to Italian Hospital; Dr. Ricardo Palma, instructor of anatomy of the Faculty of Medicine; Dr. Ricardo Paos Varela, professor of genito-urinary surgery, surgeon to Dos de Mayo Hospital; Dr. Luis de la Puente, surgeon to Maison de Santé, honorary member of the Faculty of Medicine; Dr. Belisario Sosa Artola, professor of syphilis and skin diseases, surgeon to Bellavista Hospital.

Santiago. We have already spoken of our reception at Valparaiso and of our entertainment by the surgeons of Santiago. We found a genuine desire on the part of our committee of surgeons here to cooperate and to become affiliated in the work of the American College of Surgeons. We could not have had a more influential chairman than Dr. Gregorio Amunategui, and in our formal meeting we had the services of a young medical man as interpreter, although nearly all of the Chileans understand some English. Besides the chairman, the following surgeons were discussed and recommended for our consideration: Dr. David Benavente, Dr. Marcos Donoso, Dr. Liva Eujenio Diaz, Dr. Carlos Charlin, Dr. Victor Koerner, Dr. Eduardo Moore, Dr. Olejandro Mujica, Dr. Francisco

Navarro, Dr. Correa Canpolican Pardo, Dr. Emilio Petit, Dr. Alejandro del Rio, Dr. Lucas Sierra, Dr. Jerman Valenzuela, Dr. S. Luis Vargas, Dr. Wall Jerónimo Alvarado, Dr. Silvano Sepúlveda, Dr. Alberto Adriasola, Dr. Luis Obalos, and Dr. Guillermo Muenich.

Valparaiso. It was considered desirable to consult committees in the two large cities of Chile, and accordingly we also met in conference with a selected group of surgeons in Valparaiso. We had already spent a pleasant forenoon with the members of this distinguished committee and looked forward to our conference with a great deal of pleasure. Our meeting was held in a beautiful garden in one of the favorite summer resorts near Valparaiso. The occasion was quite formal and Dr. Alberto Adriasola, the chairman, read an address and modestly suggested a few names of surgeons whom they recommended for Fellowship in the College. Among those suggested were many men whom we had already met. Including his own name, these consisted of Dr. Guillermo Muenich, who, with Dr. Adriasola, had been recommended by the Santiago committee, Dr. Silvano Sepúlveda, Dr. Frederico Engelbach, Dr. Roberto Montt, Dr. Rudecindo de la Fuente, Dr. Juan Thierry, Dr. Miguel Manriquez, Dr. Ernesto Iturrieta, and Dr. Gaston Lachaise.

There seems to be the most cordial cooperation between the surgeons of these two Chilean cities. The surgeons of this country, like the leading men everywhere in South America, are of the broadest type. Their European travel and their familiarity with several languages besides their own, gives them a breadth of vision that is frequently lacking in many of our surgeons who are provincial in spite of the very bigness of their country.

Buenos Aires. On Friday, February 6, we met the committee of surgeons of Argentina which was interested in our mission in behalf of the College of Surgeons. In the conference were Drs. Vegas, Cranwell, Chutro, and Palma. Buenos Aires has a strong body of

surgeons and surgical specialists. A modern city of a million and a half inhabitants, of necessity, would possess such a group. There are also a number of strong provinces of Argentine with cities of considerable importance. These, too, have their surgeons of quality. Our interview and discussion revealed the fact that the surgeons of this Republic are desirous of affiliating in the most cordial manner with the surgeons of the North American continent.

They submitted a list that they felt they could unreservedly recommend to the College. They also suggested a committee that would from time to time make further recommendations and pass on applications which naturally would come independent of them. It was gratifying to note the seriousness with which this group of men accepted the responsibility. The tentative list recommended contained the names of many men whom we had met on our previous visit. It is not an exaggeration to say that it would be difficult to find a group of surgeons in any capital of Europe or America which would excel the following:

José Arce	Armando Marotta
Nicomedes Antelo	Bernardino Maraini
Pedro Benedit	Arturo J. Medina
Eduardo Belaustegui	Salvador A. Marino
Enrique Bazterrica	Angel F. Ortiz
Pedro Ovidio Bolo	Pascual Palma
Adrián J. Bengolea	David F. Prando
Guillermo Besch Arana	Julio S. Passeron
Daniel J. Cranwell	Aquiles Pirovano
Pedro Chutro	Rodolfo E. Pasman
Antonio F. Celesia	Carlos Robertson Lavalle
Pedro Caride Massini	Manuel Ruiz Moreno
Máximo Castro	Rodolfo A. Rivarola
Bartolomé N. Calcagno	Alberto Rodríguez Egaña
Alejandro Ceballos	Ricardo Rodríguez Villegas
Oscar Copello	Miguel Sussini
Delfor del Valle (hijo)	Roberto M. Sole
Juan B. Emina	Ricardo Sarmiento Laspiur
Enrique Finochietto	Luis A. Tamini
Ricardo Finochietto	Herman Taubenschlag
Avelino Gutierrez	Nicolás Tagliavache
Angel G. Gallo	Marcelo T. Viñas
Marcelino Herrera Vegas	Leandro Valle
José M. Jorge (hijo)	Arturo Zabala
Guillermo Bosch Arana	José A. Viale
Luis Lenzi	Ricardo Spurr
Carlos Lagos García	Pedro Del Pino
Adolfo M. Lopez	Pedro Belou
Adolfo F. Landivar	Benjamin Abalos
Jorge Leyro Diaz	Roberto Halahan
Francisco Llobet	Eliseo V. Segura
José F. Molinari	

Montevideo. We have dwelt upon the hospitality displayed by the profession of this important and interesting city. Our official greeting here was of the most cordial nature. The committee called a meeting in the amphitheater of the new hospital and we had the pleasure of meeting several members of the Faculty of Medicine who were not surgeons. The object of our visit was reviewed by Dr. Martin and interpreted by Dr. Lagos, and then amplified by Dr. Mayo. The list of surgeons who were finally recommended is only tentative and it is to be supplemented by a few other names later on. This list is as follows:

Gerardo Arrizabalaga	Augusto Turenne
Enrique Pouey	Alberico Ysola
Horacio García Lagos	Alfonso Lamas
Lorenzo Merola	Alfredo Navarro
Manuel Quintela	Carlos A. Belliure
Juan Pou Orfila	Julio Nin y Silva

We have met in the surgeons of South America men of outstanding influence. There is something about their appreciation of worth that makes the man of education, culture, and professional ability the natural leader. Is it because of their world vision, brought about by their knowledge of foreign languages, their supplementary education in other lands, their love of general literature and the classics, and their dread of narrow provincialism?

GIFT OF \$75,000 FROM CARNEGIE CORPORATION. MUNICIPAL HOSPITALS OF NEW YORK CITY APPROVE STANDARDIZATION.

Two events of interest in the progress of hospital standardization during the past month are, first, a gift of \$75,000 from the Carnegie Corporation to the College to be used for hospital standardization; second, the hospitals of New York City, under the direction of the Department of Public Charities, officially adopted the standardization plan of the College.

The present gift from the Carnegie Corporation is the second which the Corporation has made to the College. In 1916 the Corporation gave \$30,000, making a total now

of \$105,000 for hospital standardization. This amount is supplemented by funds of the College.

"By these gifts," said Mr. John G. Bowman, "the Carnegie Corporation has done more than to give financial aid to hospital standardization. It has given encouraging approval and world-wide recognition to the work. The trustees of the Corporation voted unanimously in favor of the appropriation.

As the outcome of a meeting of the staffs of the hospitals under the direction of the Department of Public Charities in New York, held at the Academy of Medicine on the evening of January 23, plans were adopted for a review each month of the clinical records of these hospitals by their respective staffs. The medical profession in New York has long been aware that these hospitals maintain adequate case record systems for all patients; also that the laboratories of these hospitals are well equipped, well managed, and dependable. The one thing that remained to do was to institute staff meetings at these hospitals at which clear, concise reviews of what each staff had accomplished for the right care of its patients each month should be fearlessly considered. These staffs agreed unanimously that the time had come for such meetings and they therefore carried the plan through.

The data to be reviewed at the staff meetings each month are as follows, minor adjustments being made naturally as the needs of the hospital and the judgment of the respective staffs may indicate:

ANALYSIS OF HOSPITAL SERVICE.

For month ending

DISCHARGED

Cured .....	.....
Improved .....	.....
Relieved .....	.....
Unimproved .....	.....
To return for secondary operation .....	.....
Admitted for diagnosis only .....	.....
Deaths within 48 hours .....	.....
Deaths institutional .....	.....
Released .....	.....
Labor .....	.....
Newborn .....	.....
.....
.....
.....
Total Discharged .....	.....

DIAGNOSES	
Provisional and final agree.....	.....
Provisional and final disagree.....	.....
Discharged with additional diagnosis.....	.....
Discharged with no diagnosis made.....	.....
Labor.....	.....
Newborn.....	.....
Total Diagnosed.....	.....
INFECTIONS	
<i>Institutional</i>	<i>On Admission</i>
Medical	Medical
Surgical	Surgical
Obstetrical	Obstetrical
Total Infections.....	.....
DEATHS	AUTOPSIES
Medical	Medical
Surgical	Surgical
Newborn	Newborn
Stillborn	Stillborn
Total deaths.....	Total Autopsies.....
CONSULTATIONS	
Asked and obtained .....	.....
Asked, not obtained .....	.....
Indicated, not asked .....	.....

In addition to the foregoing data, analyses are also called for, first as to causes of death and, second, as to records of patients discharged as unimproved.

Chronological Statement of Hospital Standardization.

May 5, 1913—American College of Surgeons organized in Washington, D. C. Betterment of service in hospitals among objects of College.

June 22, 1914—Plan to raise permanent endowment fund for the College approved by the Fellows, the income from this fund to be used in carrying out purposes of the College.

December 1, 1915 — Endowment fund of \$526,000 subscribed by Fellows of the College.

January 27, 1916 — Gift of \$30,000 from the Carnegie Corporation, New York, to be used for hospital standardization.

September 27, 1916—American Hospital Association in session at Philadelphia invited to cooperate with College in hospital standardization. Association appointed a committee to cooperate with the College as invited.

October 27, 1916—Plan to organize State and Provincial Committees on Standards to guide and aid in the program of hospital standardization voted by Fellows.

November 30, 1916—Members of State and Provincial Committees on Standards elected by ballot.

January 11, 1917—Plan of hospital standardization, in relation to Catholic hospitals, approved by His Eminence James Cardinal Gibbons at Baltimore.

October 19-20, 1917 — Meetings of the State Committees on Standards in Chicago. Throughout two days the following subjects were considered:

1. The number, distribution, valuation, and general classification of hospitals; and the relation of hospitals to the general public.
2. What the profession of medicine wants in hospitals.
3. How to bring about desired conditions in hospitals.

About three hundred members of State Committees on Standards and sixty leading hospital superintendents present at Conference. The papers presented, together with summary of discussion, published as Bulletin, Vol. III. No. 1.

October 25, 1917—General Hospital Committee of twenty-one appointed by Regents to outline questionnaire and consider the minimum standard as advised by Conference, October 20th.

December 8-9, 1917 — General Hospital Committee met in Washington with Regents of College. An initial questionnaire formulated. Details of minimum standard considered with reference to the following: a system of financial accounting and of making annual reports; uniform nomenclature; the training of superintendents; the training of internes; the training of nurses; hospital organization; staff rules and regulations; the function of staff meetings; case records and follow-up of records; postmortem examinations; clinical laboratories; the out-patient department; the economic relation of the hospital to its community; ethics of medical practice in the hospital; education of patients and of

the community in matters of health, hygiene, and sanitation; the responsibility of the hospital to the patient; encouragement of medical research and of medical education; the hospital library; continuity of service to patients by doctors; dietetics; the testing of materials and supplies before purchase; the receiving and checking-out of materials and supplies through the hospital storeroom; model plans for new buildings and additions; and means of increasing the financial support of the hospital.

December 10, 1917 — Meeting of Governors of College in Washington. Program of hospital standardization approved. Consensus of opinion that the work should be carried out through personal inspections by staff members of the College.

February 15, 1918—General hospitals of 25 or more beds invited to cooperate with College in hospital program. Invitation and questionnaire sent to 2,711 hospitals. Copy of invitation and of questionnaire sent also to Fellows for their information.

March 1, 1918 — Minimum standard and plan of hospital standardization sent to hospitals and to Fellows. Bulletin, Vol. III, No. 3.

April 1, 1918—Work of personal investigation of hospitals begun. Investigations limited to general hospitals of 100 or more beds. Visitors or inspectors employed to explain to hospital trustees, superintendents, and staffs the hospital program of College and to make specific reports of hospital conditions as indicated by minimum standard. Report forms designed for this purpose. Cooperation of Fellows with visitors. An illustration of a visitor's report follows:

Hospital Standardization Report.

Name of Hospital: Blodgett Memorial Hospital, Grand Rapids, Michigan.

Date of Visit: March 15, 1919.

Type: General.

No. of Internes: None; usually 3.

Visitor: Anna C. Phillips.

No. of beds: 125.

No. in nurses' training school: 71.

Staff Organization: Open hospital without definitely organized staff; no review or

analysis of professional work; division of fees not permitted.

Case Records: Current records consisted only of nurses' notes, anæsthetic record in surgical cases, and final diagnoses. Occasional physical examinations and laboratory reports were found among the filed records. Records filed on shelves in general office by clerk.

Clinical Laboratories: Pathological: accessible, light, well equipped; no pathologist, no technician; facilities used occasionally by attending doctors. X-ray; accessible, well planned, completely equipped; no technician; facilities used only occasionally by attending doctors.

Notes: Conditions as to staff organization, case records, and laboratories discussed with executive committee of board and with superintendent; work of College explained. Effort being made to secure laboratory technician. Board responsive and much interested. Glad to cooperate. Ideals of all connected with hospital excellent.

Summary of Final Action Reported

August 12, 1919.

Staff Organization: Staff reorganized, meets bi-weekly to consider the character of the clinical service and other matters relative to the care of patients, such as laboratory service, etc. In the reorganization there are two groups:

1. Executive Group: Experts in special fields of work.

2. Associate Group: General practitioners.

In accepting appointment to staff, physicians and surgeons are required to agree to the following:

"To abide by the rules and regulations of the Hospital, and to adhere at all times to the well recognized, lofty principles governing the reputable practice of medicine and surgery.

"That as a principle I shall not engage in the division of fees under any guise whatever, nor knowingly permit any agent or associate of mine so to do.

"To exercise to the best of my ability a constructive interest in the Hospital, and to

cooperate in making it as potent a factor as possible in the preservation of public health in this community."

Case Records: A complete new record system instituted July 1, 1919. Complete case records including personal history, physical examination, working diagnosis, laboratory findings, treatment or operation, progress notes, and final diagnosis are kept for all classes of patients treated, free and pay.

Clinical Laboratories: The X-ray department is in charge of a full time roentgenologist; the pathological laboratory is in charge of a full time technician; serological and histological work sent to outside laboratory.

June 20, 1918 — Meeting in Chicago of Catholic Hospital Association. The following resolutions were passed:

Be it resolved, That we, the Catholic Hospital Association of the United States and Canada, now assembled at Chicago in our third annual convention, approve of the work being done by the American College of Surgeons for the standardization of hospitals, and assure the College of our fullest cooperation in its endeavor for the betterment of hospitals and the resultant increased welfare of mankind.

Be it resolved, That we, the members of the Catholic Hospital Association, pledge ourselves to organize controlled staffs in our hospitals; to establish or continue an adequate system of case records, with a Sister in charge having full authority to demand the careful cooperation of doctors, internes, and nurses; to secure from our superiors, staffs, or friends, funds properly to equip all necessary laboratories and to bring about as soon as possible the scientific training of our Sisters and technicians of all kinds, anæsthetists, dieticians, record-keepers, and social service experts.

We further pledge ourselves to urge all surgeons who are privileged to practice in the hospitals of the Association, and who are not at this time Fellows in the American College of Surgeons, to qualify as soon as they are able for Fellowship in the College.

We further wish to express our desire that all doctors who practice in our hospitals be or become, as soon as practicable, members in good standing of their respective county medical societies and contribute their share to the active medical life of said societies.

We further wish to express our conviction that the secret division of fees, as condemned by the American College of Surgeons, is an unethical and nefarious practice which we pledge ourselves to keep out or root out of our hospitals.

June 21, 1918 — Meeting in Chicago of Bishops and Archbishops (or their representatives) of the Catholic Church in the United States and Canada to consider the program of the College in relation to Catholic hospitals. Program of the College approved.

September, 1918—Meeting in Hamilton, Ontario, of the combined Surgical Section of the Ontario Medical Association and the Canadian Medical Association. The following resolution was passed:

Be it resolved, That we, the Surgical Section of the combined meeting of the Ontario Medical Association and the Canadian Medical Association, desire to go on record as approving the efforts being made by the American College of Surgeons to improve the status of surgical practice in our hospitals * * * that the right to attempt major surgery should be restricted to those who are recognized as having scientific training, experience, sound judgment, and honesty of purpose * * * that examinations for diagnosis and for treatment should be made more closely associated with clinical laboratories than they are at present. * * *

October 23, 1918 — Hospital conference arranged to be held in New York in connection with the Clinical Congress of the College. Fellows of the College and hospital superintendents of the United States and Canada invited. Meeting cancelled because of influenza.

January 15, 1919—Bulletin, Vol. IV, No. 1, published. Detailed explanation of the minimum standard with special reference to

the meaning and use of case records; 27,000 copies distributed.

January 15, 1919—Bulletin, Vol. IV, No. 2, published. Forms suggested for the keeping of case records in a simple, convenient, and adequate manner; 27,000 copies distributed.

February 1, 1919, to May 15, 1919—Hospital conferences, many of them including one or more states or provinces, arranged throughout western half of United States and Canada. Hospital standardization presented to hospital trustees, superintendents, medical profession, nurses, and to general public. These conferences usually included special meetings with county medical societies, chambers of commerce, business men's associations, and Canadian clubs. The conferences were designed to supplement the work of the hospital visitors on the staff of the College. Meetings were held at St. Louis, Memphis, New Orleans, Fort Worth, Denver, Ogden, Salt Lake, San Diego, Los Angeles, San Francisco, Portland, Tacoma, Seattle, Victoria, Vancouver, Calgary, Edmonton, Regina, Winnipeg, Minneapolis.

The following program is typical of these occasions:

HOSPITAL STANDARDIZATION CONFERENCE
PORTLAND AND VICINITY

April 11, 1919

LUNCHEON, CHAMBER OF COMMERCE, 12:15 P. M.

A. L. MILLS, Presiding

The Hospital and its Community—JOHN G. BOWMAN, Director of College, Chicago; and CHARLES B. MOULINIER, S. J., President Catholic Hospital Association, Milwaukee.

AFTERNOON SESSION, 2:00 P. M., LINCOLN HIGH SCHOOL

The Occasion for the Conference—DR. KENNETH A. J. MACKENZIE, Chairman State Committee on Standards.

What is Hospital Standardization? (Clinical Laboratories, Case Records, Staff Organization)—JOHN G. BOWMAN.

Discussion:

- (a) Clinical Laboratories — DR. A. E. MACKAY and MAJOR R. L. BENSON.
- (b) Case Records—MAJOR RALPH C. MATSON and MAJOR WM. S. KNOX.
- (c) Staff Organization—DR. S. E. JOSEPHI and DR. E. F. TUCKER.

Summary—CHARLES B. MOULINIER, S. J.

EVENING SESSION, 8:00 P. M., LINCOLN HIGH SCHOOL

Hospital Progress; The Citizen's Part—A. L. MILLS.
What the Medical Profession Wants in Hospitals—JOHN G. BOWMAN.

Team-Work for Success — CHARLES B. MOULINIER, S. J.

Summary of Conference—DR. KENNETH A. J. MACKENZIE.

September 11, 1919—American Conference on Hospital Service organized at Cincinnati. Chairmanship of committee in charge of standardization of hospital service voted to American College of Surgeons.

October 24, 1919—Report to Fellows of the College in connection with the ninth meeting of Clinical Congress of the College, New York, concerning hospital standardization as applied to general hospitals of 100 or more beds. The practical administration of the minimum standard presented.

PROPAGANDA FOR REFORM.

ACRIFLAVINE G H AND PROFLAVINE G H. —Acriflavine and proflavine have been admitted to New and Nonofficial Remedies. However, the products sold by the Heyl Laboratories as "Acriflavine G H" and "Proflavine G H" have not been accepted for New and Nonofficial Remedies because (1) their quality did not conform to the Council's standards, and (2) in the advertising issued for these drugs the manufacturer failed to give the unfavorable as well as the favorable clinical reports that have been published (*Jour. A. M. A.*, July 3, 1920, p. 51).

ANTIDOTE FOR SNAKE POISON.—No anti-venom for snake poison has been accepted for New and Nonofficial Remedies. Experiments looking toward the production of anti-venom for snake poisoning seem to have met with some success, but the use of these products in therapy is still in the experimental stage. In general, it has been shown that an anti-venom prepared for one species is not always effective when used against the venom of another species. (*Jour. A. M. A.*, July 3, 1920, p. 51.)

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"CHRISTIAN SCIENCE" AND SLOPPY THINKING.

A New Jersey salesman, who claims to have been a member of the "Christian Science" faith for three years, was recently found guilty of manslaughter because he had permitted his nine-year-old daughter, who was suffering from diphtheria, to die without medical treatment. The little girl was given "treatment"—"absent" and otherwise—by a professional "Christian Science" practitioner. The man was fined \$1,000 and costs. The judge, in imposing sentence, is reported to have said:

"In the light of present-day science, which is the result of many years of progressive experiment and demonstration, no one is justified in neglecting the use of such agencies as have been shown to be efficient in the treatment of malignant and contagious diseases, and this is especially true where one is charged with responsibility over the life of another, and particularly of a child of tender years, who has no option but to rely on the common sense and good judgment of its natural protector."

The verdict has brought to light, as such verdicts are likely to do, the loose thinking that characterizes so many of the so-called intellectuals of today. Well-meaning people, who deny that they are followers of Mrs. Eddy, have written to the newspapers denouncing the verdict and declaring that it is little less than a crime that a man should be punished for following the dictates of his conscience. The main point stressed by such people seem to be that as children occasionally die of diphtheria under medical treatment, there is no reason for getting excited when a child dies under "Christian Science" treatment. The argument, of course, is fallacious. The efficacy of the modern scientific medical treatment of diphtheria is not a matter of theory, belief or conscience—it is a matter of fact. Its efficacy is as demonstrable as is the efficacy of the Westinghouse air brake. The parent or guardian who fails to give his child or ward the benefit of modern medical treatment for diphtheria

becomes as culpable as a railroad would be if it failed to equip its passenger trains with air brakes. Sometimes, it is true, the air brake fails to avert a fatality; but that is not the fault of the air brake, nor is it any argument for its abolition.

If an adult in his own right mind wishes to be treated by "Christian Science" or any other unscientific methods, there can be no objection, provided the disease from which he is suffering may not, through such treatment, become a menace to the community. Children of tender years, however, should not be sacrificed to the distorted views of those who are supposed to be their protectors.

Religious beliefs should be respected and, in general, they are respected. Where, however, religious beliefs conflict with the general welfare, such beliefs must give way. Presumably, the Mormons were sincere in their belief in polygamy; that particular tenet of their religion, however, had to give way to the more enlightened belief of the rest of the community. The Dukhobors that migrated to Canada were undoubtedly sincere in their belief that they should go nude, and the practice of this belief was undoubtedly less of a menace to the community than are some of the bizarre views held by "Christian Scientists" regarding the cause and treatment of disease. Nevertheless, the Dukhobors had to put on clothes. It is conceivable that we might have transplanted to this country some of the religious beliefs of India, but it is doubtful whether public opinion in the United States would ever look with equanimity on Sutteeism, even though the widows might declare that being burned on the funeral pyres of their deceased husbands was a matter of their own personal belief and was none of the concern of the general public. Only a few weeks ago a man in Chicago shot his son with the avowed intention of killing the boy because he feared the lad was acquiring bad habits and he wished to save the boy's soul. We have not yet noticed any letters of indignation protesting against the man's arrest. Possibly this is because he represents a minority. Should

such beliefs ever reach the dignity of a religious cult with money and well-organized publicity machinery behind it, there would doubtless be found many to defend the killing of minors for the purpose of saving them.—*Jour A. M. A.*

NEW POPULAR HANDBOOK ON CANCER.

Just prior to the entrance of the United States into the world war the Advisory Council of the Society appointed the following special committee to supervise the preparation and distribution of a handbook on cancer, for circulation among public health workers and the laity: Dr. Francis Carter Wood, Director of Cancer Research of the George Croker Special Research Fund, Columbia University, New York City, Chairman; Dr. James Ewing, Professor of Pathology at Cornell University Medical College and Director of Cancer Research at Memorial Hospital, New York City; Dr. Harvey R. Gaylord, Director of the New York State Institute for the Study of Malignant Disease, Buffalo, New York; Dr. E. E. Tyzzer, Professor of Comparative Pathology and former Director of the Cancer Commission at Harvard University, Boston, Massachusetts; and Dr. Frederick L. Hoffman, Third Vice-President and Statistician of the Prudential Life Insurance Co., Newark, New Jersey.

After unavoidable delay due to the war this committee completed its work and submitted the revised final draft to the Advisory Council for critical review, and after all possible suggestions had been incorporated, the material was accepted and ordered published with the endorsement of the Council, and in the name of the Society on June 4, 1919.

Soon after completion and while waiting the reorganization of the Society's work following the war and the necessary readjustments incident upon the resignation of Mr. Lakeman and the appointment of the new Executive Secretary, a request was received from the New York State Depart-

ment of Health for a series of papers relating to the subject of cancer and its control for a special cancer number of its monthly publication *Health News*. As the material contained in the new booklet was exactly of the nature of the article required it was decided to comply with this request by allowing the Health Department the privilege of using this material for their cancer number. The first printing of this pamphlet, therefore, came out as the February, 1920, issue of *Health News*, an edition of 20,000 being printed for circulation among physicians, health officers, legislators, public officials, and welfare agencies of New York State.

Similar use is to be made of this material by the New York City Department of Health which plans to issue this booklet as a special monograph on the subject of cancer. It will go out to a special mailing list of public health and welfare workers and general libraries, not only in New York City, but in all the large cities of the country.

The central office will soon have its own edition of this handbook for distribution and has secured figures for reprints. As soon as copies are available a circular letter will be sent to all state and large city health departments urging them either to secure reprints or to print the booklet themselves for their own distribution.

NEW AND NONOFFICIAL REMEDIES.

POLLEN ANTIGEN-LEDERLE (FALL TYPE).—A liquid obtained by extracting equal

parts of the pollen of ragweed, goldenrod, wormwood and maize. Each cubic centimeter contains 14,000 pollen units (a pollen unit is the equivalent of 0.001 mg. of pollen). This liquid is made into fifteen different dilutions. The product is supplied in packages containing the fifteen dilutions (to be used for prophylactic treatment), in boxes containing five of the dilutions (series A, B and C, respectively), and in packages containing a single tube (for diagnostic use). Lederle Antitoxin Laboratories, New York.

WHOLE OVARY-H. W. D.—The ovarian gland of the cow, including the corpora lutea, freed from extraneous matter and dried in vacuo. For actions and uses, see general article on Ovary (New and Nonofficial Remedies, 1920, p. 201). Whole Ovary-H. W. D. is sold in the form of 5-grain tablets only. Hynson, Westcott & Dunning, Baltimore.

BENZYL BENZOATE-ABBOTT.—A brand of benzyl benzoate (see New and Nonofficial Remedies, 1920, p. 49) complying with the N. N. R. standards. It is also supplied in the form of Elixir Benzyl Benzoate-Abbott and Benzyl Benzoate Tablets-Abbott, 2 grains. Abbott Laboratories, Chicago.

GNOCOCOCCUS GLYCEROL-VACCINE (LEDERLE).—A suspension of killed gonococci in a vehicle of glycerol and physiological solution of sodium chloride. For a discussion of gonococcus vaccine, see New and Nonofficial Remedies, 1920, p. 283. Marketed in packages of fifteen vials containing progressive amounts of the vaccine. (*Jour. A. M. A.*, July 17, 1920, p. 177.)

PUBLISHER'S NOTES

THE CASCARA HOUSE.

The knowledge gained by many years of persistent study of the development and improvement of medicinal preparations derived from a vegetable drug is bound to command respect. To Parke, Davis & Co. the medical profession owes the introduction of Rham-

nus Purshiana almost half a century ago. By intensive application to methods of extraction and preparation this firm has ever since maintained the efficiency and pharmaceutical elegance of its cascara products. The appellation "The Cascara House," as applied to Parke, Davis & Co., is singularly appropriate.

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ORIGINAL ARTICLES

DIARRHEAS OF INFANCY.*

M. B. HERLONG, M. D.,
Jacksonville, Fla.

Diarrhea is a symptom of an irritated bowel, the stimulation excited by either one or more of four ways: Nervous; mechanical; fermentation (carbohydrate, protein); infection (dysentery bacillus, gas bacillus, other facultative bacteria).

These irritants cause an increased peristalsis of the bowels and increased activity of the glands of the bowel, with a pouring into the bowel of the fluids of these glands extracted from the body fluids, causing a rapid passing of the contents through the bowels.

Diarrhea has been credited with causing the death of one-seventh of all children, and statistics of the Public Health Department at Washington show that it causes 25.7 per cent of all the deaths during the first year of life.

Herman reported that in 1905 33 per cent of all deaths during the first year of life in Berlin was due to digestive disturbances, chiefly diarrhea. Still, of London, reports that from 2,000 to 4,000 infants annually died from diarrhea, or 18.88 per cent of total deaths during first year of life.

Etiology.

That age is a predisposing cause is conceded. Of the first five years the percentage of death from diarrhea is as follows: First year, 65.7 per cent; second year, 13.7 per cent; third year, 6.1 per cent; fourth year, 3.8 per cent; fifth year, 2.7 per cent.

Seasons play a very important part, as the summer months are most favorable to its spread. This can be accounted for in two ways—in that it is the fly-breeding period

and that they spread infection. This point has been brought out by Dr. C. E. Terry, while City Health Officer of Jacksonville. One year there was quite an epidemic of diarrhea here during the first months of summer, but when the rainy weather set in during July and August and flies could not travel so far and their breeding places were wet and unfavorable, there was a very perceptible decrease in diarrhea.

And also in summer milk undergoes chemical changes much quicker than in winter and bacteria multiply more rapidly. Poverty, crowding, uncleanness and previous state of health and last, but not least, ignorance and carelessness are predisposing causes.

The nervous or reflex type may be brought on by heat, cold, fright, pain, fatigue, or infections outside of the digestive tract as in middle-ear infections, empyema, pyelitis, or uremia. In this type we hardly get the extreme depletion we get in the fermentative or infectious types, and there are not the alarming symptoms. The child, unless suffering from an infection outside the digestive tract, does not show any, or very little, rise in temperature, the stools are loose and show particles of undigested food owing to the rapid passing through the digestive tract; they do not show an excess of mucus, but are watery and have not the foul odor found in the more severe types. I have seen most such cases after traveling or changing from one place to another. The treatment is to stop all food for twenty-four hours and quiet the nervous system and usually to put them in a darkened room, or a little sedative (sodium bromide) is sufficient.

If it is from some outside infection, of course, the treatment of that infection is indicated.

*Read before the forty-seventh annual meeting of The Florida Medical Association, at Daytona, May 12-13, 1920.

Mechanical.

This type is due to foreign bodies as seed, skins of fruit, husks of corn, beans or other fibrous material, and is most often seen in infants that are creeping over the floor. These particles irritate the glands and mucosa, causing them to pour out fluid and stimulate peristalsis.

There is usually pain of a colicky nature and very little vomiting, as the offending matter is below the stomach, and there may or not be fever. The stools, of course, show undigested particles. The treatment is a good purge of castor oil to sweep out the offending matter, rest the digestive tract by giving only barley water and gradually increase feedings after twenty-four hours.

Fermentative Type.

This type is seen most often, in fact you will see almost 100 cases of this type to one of the other, and in these cases your patient is a very sick one and death may occur in twenty-four hours. In these cases you get the symptoms of the nervous and mechanical plus a toxic condition from absorbing the end products of fermenting food.

This type is divided into the carbohydrate and the protein forms. The carbohydrate form is most often seen and the one in which you get the extreme symptoms, but it must be differentiated from the protein form, for, as you will see, the feeding is to be entirely different. This form is seen most often in babies fed on the condensed milk and have developed a sugar intolerance, or who have been overfed on carbohydrates, and the sugars that are not absorbed broken up into acetic acid.

These acids irritate the mucosa, stimulate peristalsis, and the capacity of digestion for other foods is lessened.

The child spits up a thin, watery, sour-smelling frothy vomit. At times you can make your diagnosis from the odor alone. The child is fretful and craves water continuously, as nature is trying to neutralize the acid in the intestines. There are ten to forty stools in twenty-four hours of a thin, watery, sour-smelling, green color; the but-

tocks become excoriated from these violent acids. As I stated, fats also do not digest and they break up into buturic and formic acid. The child becomes dehydrated very quickly, the abdomen is sunken as are the eyes and fontanels, the skin becomes dry and of a waxy cast, the eyes remain about half open while asleep.

An acidosis is quickly developed due to the glands of the intestines pouring in the alkalies of the body trying to neutralize the acid contents of the bowel and absorption of acids into the general system.

This condition is the cholera infantum of old, the summer complaint, the ileo-colitis.

The continuity of the mucus membrane is not broken, but you must picture the condition of the delicate tissue after the effect of these violent acids. The entire gastro-enteric tract is irritated, congested and engorged, the glands are excreting above their capacity. The muscular coats are in an almost constant spasm of contractures and the stools are almost continuous; the temperature runs from 99° to 104° and 105° F. The prognosis is grave when the disease has extended over forty-eight hours, and you may have to combat acidosis, pyelitis or meningitis.

Treatment: Purgatives are not indicated, as the bowels are already irritated and throwing off all that is possible. Stop all food for twenty-four hours, using barley water every three hours. Give all the fluids possible in any way you can—sodium bicarbonate intravenous or intraperitoneal, glucose intravenous or intrasinus, Murphy drip of sodium bicarbonate or normal salt, normal salt hypodermoclysis, or in any other way you may, but get in the fluids. After twenty-four hours put child on a protein diet, cut out all sugars and fats.

Give buttermilk or lactic acid milk (made after skimming the sweet milk), Eirweiss Milk of Finklestein, or skimmed milk with powdered casein, as these break up into alkalies and the food value is present. Drugs do very little good. I saw the case histories of several thousand children, and those that were treated only by dieting did as well as

those who were given bismuth, although bismuth does no harm. Lactic acid tablets or Bulgarian bacillus tablets would seem to introduce the living bacteria along the intestinal tract and help some.

If stimulation is indicated, and it usually is, give caffein sodium benzoate gr. $\frac{1}{8}$ to $\frac{1}{2}$, hypodermically, or a little whiskey, camphorated oil, hypodermically, or coffee enemata.

The protein form may show practically the same symptoms, although these are rare cases and you rarely see one; the treatment is to cut out proteins and give carbohydrate food; the stools are brownish, musty-smelling, with tough curds in them and alkali in reaction; give a 6 to 8 per cent milk sugar until the stools change, and gradually add proteins. In this you do not get the excoriated buttocks as in the carbohydrate form.

Infectious Type.

The predisposing causes are the same as in the fermentative type and the child may have started out with one of the other types, but now you have the diarrhea, the toxic symptoms plus an infection of the bowel itself with ulceration.

The pathology is practically the same as in typhoid fever and the course is practically the same; the stools contain blood mucus and pus, the ulcerations are not confined to the Peyer's glands, but from the rectum to the stomach, although mostly in the colon.

The exciting cause is the bacillus dysentericus, the bacillus aerogenes capsulatus and other bacteria that are facultative pathogenic. It is important that these be differentiated, although the gas bacillus is not so common as the dysentericus bacillus type, but the feeding in the one case is diametrically opposite the other — you should know which one you are dealing with, and the diagnosis is easily made. You take a small portion of stool and add enough milk or sugar solution to fill the long end of a fermentation tube, you boil for three to six minutes and then fill the long end of a sterile fermentation tube and put away at room temperature for twenty-four hours, and if fermentation has taken place to any extent and gas is formed

in tube, we know that we have a gas bacillus infection, as the boiling kills all bacteria and only the spores of the gas bacillus can withstand boiling; so if we find it is not a gas bacillus, we must feed a food of carbohydrates, as these break up into acid end products which are inhibitory to the growth of the dysentericus bacillus; or if gas bacilli are found, we feed on proteins, as these break up into alkali end products which are inhibitory to the growth of gas bacillus.

Drugs are of little avail; we do not wish to bind up the pus and mucus in the ulcers formed in the walls of the intestines, unless there are a great many movements and they are drawing off too much fluid from the body and it seems imperative for us to do something desperate, then use opium only to check them partially, and bismuth would seem to help; but there is a question as to the good it does, and it certainly masks the stools.

Colonic irrigations of some alkaline solution that will tend to clear the ulcers and neutralize the acidity and increase the body fluids are indicated, and I think sodium bicarbonate or the alkaline antiseptic solution is good, care being taken that the solution is given very slowly so as not to excite peristalsis. A good way is to use a fountain syringe and have the bag only two or three inches above the abdomen.

This will allow your patient more fluids and often so neutralize the acid contents of the colon that your patient will fall asleep from the relief so given.

Dieting should be your sheet anchor, never losing sight of the fact that your patient is pouring out a great amount of fluids that in some way must be replaced.

THE PROBLEM OF PHYSICAL ILLITERACY.*

GRACE WHITFORD, M. D.,
Ozona, Fla.

We are in the throes of the movement for "Americanization" in these United States.

*Read by title before the forty-seventh annual meeting of The Florida Medical Association, at Daytona, May 12-13, 1920.

Slowly, after the lessons of the great war, we have awakened to the fact that we have millions of adults in our country, many of them naturalized Americans, residents for years, who neither read nor write this nor any other language. Still later, someone compiled figures showing how many native-born Americans could do neither—these millions are more startling and give us greater shame. Twenty per cent of our adult rural population cannot read; in seven states, more than twenty per cent of those over ten years are illiterate. Then we have gone a little further and begun to consider our moral and physical illiterates. Elimination of the three phases covers the true scope of "Americanization."

As physicians, our work in Americanization should lie in the removal of physical illiteracy. It is safe to say that every adult who cannot read is a potential physical illiterate, at least; in addition to these millions there are many more, although considered literate, who know little or nothing of personal or community hygiene. In spite of our great progress in medicine and prophylaxis, we have great epidemics periodically. We lost thirty-one thousand men in action in France during the World War; during one year in our own land, pneumonia and tuberculosis killed seven times as many individuals — 217,000. The slogan of one of the successful health movements during the war was, "It is safer to be a man in the trenches than a baby at home." The risk is not limited to babies! It means a tremendous crippling of all industrial and commercial life. We have made great strides in the improvement of health conditions in the last twenty years; still the annual illness, most of which is preventable, among American workingmen costs the nation two billion dollars annually. Great industrial plants, factories, stores have awakened to the loss and have gradually installed systems of physical examinations, clinics, surgical dressing rooms, dental clinics, health education, home visiting, care of workingmen's families, etc., for some years. They point to the raising of the physical efficiency of their men and to increased production,

giving gains in dollars—the strongest industrial argument. Life insurance companies were early in the field with nursing systems, largely for the health education of their policy holders and their families.

Leaders and veterans in the work of health education tell us that the place to begin such education is with the children; that we only palliate the present in dealing with adults. My own small experience corroborates this. Obviously, the easiest and most economical place with which to begin is the school—the only place where large groups of children are habitually gathered together under supervision. Statistics show us that 75 per cent of the school children of rich America are suffering from physical defects; 1 per cent is mentally defective, 1 per cent has cardiac lesions, 5 per cent are tuberculous, 5 per cent have defective hearing, 25 per cent defective eyes, 20 per cent malnutrition, 20 per cent adenoids, diseased tonsils, or glandular defects; 15 per cent joint defects, 50 to 75 per cent defective teeth. My analysis of 20,920 school children of fifteen different counties of different sections of Florida shows: Anaemia, 37 per cent; enlarged glands (mostly cervical), 53 per cent; nervous diseases, .002 per cent; pulmonary diseases, .007 per cent; cardiac diseases, 2.5 per cent; orthopedic defects, 8.2 per cent; conjunctivitis, 13 per cent; trachoma, 13 per cent; defective vision, 10.9 per cent. (No reliable mental survey has ever been made in the state.) The venereal record of Florida you all know. Obviously, we need to take heed for the coming generation. The results of investigation in many cities, counties and states of this country have lead to immediate measures for the remedying of physical defects, underlying causes, environment. But every community doing such work has found the greatest preventive necessities to be physical education and training — in other words, the removal of physical illiteracy and the raising of the individual health standard. After all, proper physical training is applied hygiene. One of our states, a great eastern commonwealth, received a blow to her pride

and patriotism when fifty-five per cent of her first draft applicants were rejected. In her thorough-going way, she sought the cause, finding nearly every man rejected a physical illiterate, even though he had the appearance of strength and looked a seemingly good physical specimen. Going further in her self-examination, she found that health education had been grossly neglected in her school system, particularly in the rural districts. She is now installing a splendid system modeled after the best in this country. She came to realize that her children had physical rights as well as her cattle; that their raising demanded attention, as did that of her crops.

Sir Alfred Pearce Gould pithily says: "It is penny wise and pound foolish to build costly schools, to provide well-trained and skillful teachers and give them tired, worried, hungry, or sleepy children to educate."

Today the problems of health, efficiency, illiteracy of all kinds are as striking as they were during war preparation—perhaps more so in a world seemingly gone mad. We must build up our health resources, develop our reserves.

Undoubtedly, before long a Federal program for health education will develop. We must be alive to what we need and want in Florida. I fear that the average physician does not feel his responsibility in the matter of the physical illiteracy of his own community. Too often he is content to attend the extremities of life and death to which he is called, not taking the initiative in civic matters of health; he does not train his people to look to him as a leader and deserve to be considered an authority. It is small wonder that the isms, mechanical and medical fakes, patent medicines with their misleading, would-be scientific advertising, thrive as they do, for often the local physician seems apathetic about what he does not consider affects his individual practice. He should be a leader in his community in planning the raising of the physical ideal. The city, county and state medical societies should be

aggressively active in this work. I doubt not that many medical society meetings might be more attractive to a greater number if an occasional meeting were devoted to a general consideration of the physical needs of the community, county, or state, making each section a complete study, and forming the proper program for the improvement of the physical aspect of their field and the raising of the physical standard in the personal and civic life of the people.

In closing, may a quotation be pardoned? Mark Twain says, "Everybody is constantly talking about the weather and nobody ever does anything!"

As physicians in a state having an exceptionally large health appropriation, let's get about doing something definite about Florida's physical illiteracy!

CASE RECORDS*

(ANTE-MORTEM AND POST-MORTEM) AS USED IN WEEKLY
CLINICO-PATHOLOGICAL EXERCISES AT THE
MASSACHUSETTS GENERAL HOSPITAL

EDITED FOR THE USE OF PRACTITIONERS BY

RICHARD C. CABOT, M. D., AND

HUGH CABOT, M. D.

F. M. PAINTER, ASSISTANT EDITOR

CASE 6251.

First entry. An Irish housewife of thirty-five entered August 12, seventeen years before her final admission, for relief of leucorrhea, cystocele and lacerated peroneum. She had had dull aching pains in the back and sides and frequent headaches.

Dilatation and curettage was done, and posterior colporrhaphy, trachelorrhaphy, and ventral suspension. August 29th she was discharged much relieved.

Out-Patient Department. May 12th after the last entry she returned for relief of severe headache of five weeks' duration, worse on the left side of the head. Myopic astigmatism was found and glasses were fitted. Two years later a Wassermann was strongly positive. The following June she was uncon-

*Published in THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION with the permission of the Massachusetts General Hospital.—Ed.

scious for three weeks. In March of the next year Wassermann was negative.

Second entry. May 5th she returned to the wards.

P. H. She had always been healthy. She had had mastoiditis with headaches for one year, relieved by operation six years ago at the Eye and Ear Infirmary. Two years ago she had a recurrence of mastoiditis treated at the New England Baptist Hospital without operation. For four or five years she had had some palpitation and dyspnea on exertion, and her heart was "bad during spells." Her bowels were constipated. Recently she had urinated three to four times a night. Cta. now every three or four months. For six months she had had an eruption on the body.

P. I. In June, two years ago, following a severe headache and general malaise, she collapsed on a street car, became unable to speak, and lost control of the right side of body. She recovered in about half an hour. On walking home she had another similar attack lasting two hours. After two weeks in a hospital she recovered fully and went to work. In December she was sent to a hospital with a diagnosis of pneumonia. She stayed at the hospital two weeks, then spent four months in convalescent homes. She had very little strength. In June she started to work again. Then she had a fall from a trolley car, bruising her left knee. Two days later, following another severe headache, she became unconscious and had a convulsion (?). She was taken to a relief hospital and in two weeks regained her memory. Her speech was slow and halting and she had no control of the right leg and arm. The use of her leg returned nearly to normal, but the arm was still very clumsy. She had to learn again to write. The difficulty in speech was in thinking of the words she wanted to use. She talked more fluently some days than others. Her daughter thought she understood normally, and that her memory was good.

P. E. Well nourished. Scleræ slightly injected. Teeth poor. Pyorrhea. Tongue: Slight tremor. Movements clumsy. Pulses normal. Artery walls palpable. *Heart* not

enlarged to percussion. Systolic B. P. 225, diastolic 110. *Abdomen:* Liver 4th rib to costal margin. *Extremities:* Fingers of right hand slightly hyperextended. Movements of right hand performed fairly accurately, but after delay of some seconds. Left knee stiff and held slightly flexed. *Reflexes* active. Possible slight sensory disturbance on the right. Muscle sense of feet somewhat uncertain. Some hesitancy in speech due apparently to inability to find or remember words. *Fundi:* Vessels tortuous and full. Many small areas of pigmentation (old hemorrhages) over both retinæ.

T. 97°-98.5°. *P.* 60-90. *R.* 20-40. *Urine:* Amount not recorded. Sp. gr. 1016-1018. Slightest possible trace of albumin at one of two examinations. *Renal function:* In two hours 40 per cent. *Blood* not recorded. *Wassermann* weakly positive. Report of *oculist:* Myopic changes in choroid. Also a disseminated choroiditis, probably specific.

May 6th lumbar puncture was attempted. As she was quite obese and could not assume a satisfactory position the periosteum was entered several times. She complained slightly of pain. After several minutes she seemed to lose consciousness and her color became palé. Her pulse remained good. She regained consciousness in about four minutes and talked normally. She complained of pain in the back of head and cold. May 8th, after going to a dentist, she had another period of unconsciousness lasting two minutes. May 10th lumbar puncture was done without difficulty, giving 5 c. c. of clear fluid, no cells, proteins not increased, Wassermann weakly positive. May 12th she had headache. May 14th she was discharged unrelieved to the Out-Patient Department.

Third entry. December 28th, a year and a half later, she reentered.

P. H. For five years she had urinated three or four times nightly. Since leaving the hospital her health had continued about the same as before. She was fairly comfortable. She did not attempt to work. She had had no more headaches, but had some palpitation and shortness of breath on rather slight

exertion. She had not noticed nocturnal urination of late.

P. I. Two days ago she was sick with headache and thought she had a "stroke." She did not remember. She had a retrograde amnesia, and it was very difficult to obtain any history of events before the attack. She was found unconscious by her daughter and brought to the hospital. Consciousness she said returned yesterday morning. She discovered she had quite a severe cough. She thought she fell on the stairs.

P. E. Well nourished. Slightly cyanotic, semicomatose. Replied senselessly to questions. Mucosæ slightly cyanotic. Neck stiff. *Lungs*: Many moist and consonating rales on inspiration, sonorous rales especially. Heart sounds muffled, very hard to hear on account of rales, fair quality. No enlargement to the left. Right border and supracardiac dimensions questionable. Systolic B. P. 165, diastolic 110. *Abdomen*: Liver dullness 5th rib to costal margin. Edge not felt. *Pupils*: Irregular, reacted sluggishly to light. *Fundi*: Blurring of the disk edges with overlapping vessels and white areas. *Reflexes*: Knee jerks not obtained. Double Babinski, double Gordon, double Oppenheim. Questionable Kernig on the right. Uriniferous odor to body.

T. 97.3°-100.5° until January 8th, then not remarkable until January 17th. *P.* 61-91 until January 14th. *R.* 17-31 until January 17th. See history for later chart. *Urine*: § 10-36 except January 1st, then § 89. Systolic B. P. 140-200, diastolic 90-120. Sp. gr. 1012-1018. Alkaline at two or four examinations. Slightest possible trace of albumin at one. Rare leucocytes at one. *Renal function* 33 per cent. *Blood*: *Hgb.* 75 per cent. Leucocytes 18,600-9,800-14,000. Reds 4,590,000. Non-protein nitrogen 65.4 mgm. per 100 c. c. of blood. *Wassermann* negative. *Lumbar puncture*. Needle introduced through dura at first attempt without any trial removal of stillette. 18 c. c. of hemorrhagic spinal fluid obtained under normal pressure. *Wassermann* and culture negative. *Eye consultation*: High myopia; old choroiditis (cen-

tral); vitreous opacities. Veins rather large and tortuous. Arteries small. *Widal* negative.

The day after entrance the patient became conscious and remained so. Her speech and memory were normal and the reflexes returned to normal. For two days she was completely anuric. The third day she voided § 34, the fourth § 16. By January 1st her only complaint was severe headache. This improved. She was up and about, and January 17th was discharged. That day, however, while quietly sitting in her chair, she suddenly cried out with pain in her head, fell over, and soon lapsed into unconsciousness. She remained in deepening coma, with Cheyne-Stokes respiration, vomiting considerably. There were signs of pneumonia at both bases. The systolic blood pressure rose from 150 to 200, the diastolic from 90-120. The temperature, pulse, and respiration rose, reaching 105.9°, 142, and 50 respectively. January 23d she died.

DISCUSSION.

BY DR. RICHARD C. CABOT.

NOTES ON THE RECORD.

The years are a little unclear in this history. Apparently about five years have been covered by the record of the first entry and the Out-Patient Department, and the second entry is about ten years after that.

Whether the headaches at this time had any connection with the trouble which they thought they had cured with glasses I do not know. I do not know whether it is the same side of the head or not.

In her past history the dyspnea and palpitation and the nocturnal urination were the most important things.

The third left frontal convolution, the speech centre, would correspond with the right-sided paralysis that we have here, making it natural that she had aphasia. This was all two years before her second entry.

She had three of these spells of unconsciousness and convulsions; presumably she had lost her memory at the time she became

unconscious last. Certainly the left side of the brain was affected.

From the blood pressure we know that the heart *is* enlarged, whether it is enlarged to percussion or not. We never have such a blood pressure in such a case as this without a big heart.

We have pretty good evidence of syphilis in the fact that she had a strongly positive Wassermann and an unconscious fit at an age when we should not expect the ordinary type of arteriosclerosis, and later more unconscious fits, which were recovered from and were also in a fairly early stage of her life. Now she turns up with high blood pressure, retinal hemorrhages and imperfect use of the right side of the body and speech centre, all of which point to a lesion toward the forepart of the left side of the brain. The choroiditis tends to back all this up.

Up to this point we should say she probably had syphilis hitting the arteries in the brain, producing more or less premature arteriosclerosis, and a lesion on the left side of the brain, very possibly blocking without hemorrhage; and also arteriosclerosis affecting the heart and causing hypertrophy and dilatation. The kidneys seem to be good—forty per cent function.

In attempting the lumbar puncture they ran against the bone instead of running into the proper hole. I judge they never got in; they do not say anything about it. If the dentist could make her unconscious as well as the man who was trying to puncture the spinal cord, that made them feel better. They got nothing out of the later puncture except a little more evidence about syphilis.

I do not see why nocturnal urination should stop. Perhaps she forgot it.

It does not say where in the lungs the rales were—I suppose everywhere.

The diastolic blood pressure is just the same as it was before. That gives us the most important information about blood pressure. If we can have only one we would rather have the diastolic. It tells much more than the systolic.

In the neurological examination there is nothing more marked on one side than on the other except the Kernig.

DIFFERENTIAL DIAGNOSIS.

A story of arteriosclerosis as I see it, with terminal pneumonia very possibly. We ought to find something in the brain. Was the brain examined?

Dr. RICHARDSON: Yes.

Dr. CABOT: Then we will commit ourselves. I do not try to discuss things unless we are going to know. Although she had various transient lesions, she had at least one the effects of which remained for months and years, and that is the one probably in the forward left side of the brain. Hemorrhagic spinal fluid, if they are sure they did not get the blood in when they tapped—and they ought to be able to be sure of that—is present more than half the time with fresh cerebral hemorrhage. It seems then that she had had a fresh hemorrhage. The heart should be hypertrophied and dilated, but we have no evidence of anything more than that. The lungs are stated offhand to show some pneumonia. Very likely they did; but in a good many cases where such a statement is made they show only passive congestion. It is very hard to tell in a comatose patient of that type what is going on in the lungs. We make a great many more mistakes about the lungs in people with coma than at any other time. The kidneys should be pretty good, should show no nephritis in spite of the fact that she stopped passing urine for two days. I do not altogether understand that, but I do not think with the other evidence it compels us to say she had any extensive nephritis.

As to the therapeutics of this case, in the stage at which we saw her last I do not believe anything could have been done. Whether anti-syphilitic treatment was pushed in her early years as it would be now I think is very doubtful. Now we have a great deal more hope of accomplishing something than seventeen years ago, and so we follow up our syphilitic cases. So if there was any flaw it was at the beginning when arterial changes

were perhaps preventable. Lumbar puncture did her no harm and no good.

A PHYSICIAN: Could one attribute the high blood pressure to her cerebral condition?

DR. CABOT: So far as I understand the record she had high blood pressure even when not comatose, and in the absence of coma that would point, I think, to something more than the brain lesion.

A PHYSICIAN: Can you discuss the Wassermann—negative one time, positive another?

DR. CABOT: We cannot really tell very much about that without knowing what we do not know, the details of treatment. We hope to be able to make a Wassermann negative, and whether between those times they were giving her mercury we do not know. In the first entry it was strongly positive, then negative, then it was positive in the spinal fluid at one time.

A PHYSICIAN: Does alcoholism affect the Wassermann?

DR. RICHARDSON: I do not know.

A PHYSICIAN: I have heard it said that if a man goes on a drunk and a Wassermann is taken within a day or two of that time it is negative.

DR. YOUNG: I understand that an acute alcoholism does something to abolish a Wassermann, while chronic alcoholism does not.

DR. REGINALD FITZ: I think you have underestimated the importance of the kidneys and overestimated the importance of syphilis.

DR. CABOT: I do not think we shall have any post-mortem evidence of syphilis. All I have to go on is that she began having brain troubles so early, at a time when one does not ordinarily get arterial troubles without syphilis.

DR. REGINALD FITZ: You have high blood pressure, albuminuria, eye-ground changes lasting for a long time. These signs almost always spell nephritis.

DR. CABOT: Forty and thirty-three per cent renal function. These do not affect you?

DR. REGINALD FITZ: No.

A PHYSICIAN: What do you think will be found in the brain—gumma?

DR. CABOT: No. I think there should be evidence that an artery has been obstructed, old softening or cyst or the staining that comes when there has been hemorrhage. What do you think, Dr. Fitz?

DR. FITZ: I think arteriosclerosis, old scar or thrombus, possibly a hemorrhage from an artery, but I doubt it.

DR. CABOT: You think about the same as I do, only you think there will be more found in the kidney. Certainly a lot can be explained with uremia. But my point is that it can be explained without uremia, and that the report of the urine as given in the gravity, amount, and phthalein examination does not compel us to say she had any nephritis.

Clinical Diagnosis (from Hospital Record): Cerebral hemorrhage; arteriosclerosis; syphilis.

Dr. Richard C. Cabot's Diagnosis: Arteriosclerosis (cerebral and general); cerebral hemorrhage; hypertrophy and dilatation of the heart; terminal pneumonia.

ANATOMICAL DIAGNOSIS.

1. Primary fatal lesion.—Arteriosclerosis of the vessels of Willis with area of hemorrhage and disintegration of the bases of the wall of the third ventricle, and hemorrhage into the ventricles.

2. Secondary or terminal lesions.—Edema of the pia; slight hypertrophy and dilatation of the heart; bronchopneumonia, left lung; soft spleen.

3. Historical landmarks.—Scar of old operation wound, ventral fixation; chronic perisplenitis; slightly defective closure of the foramen ovale.

DR. RICHARDSON: This is a case of arteriosclerosis of the vessels of Willis with only very little arteriosclerosis in the aorta and great branches. The heart showed moderate hypertrophy and dilatation. The valves were in very good condition.

The kidneys were out of the picture.

Posterior to the optic chiasm the vessels of Willis showed more arteriosclerosis than

elsewhere, and were lost in a mass of blood clot which was continuous with an area of disintegration at the base of the wall of the left ventricle and the ventricles lateral third and fourth, containing a large amount of blood clot—a frank hemorrhage of the brain.

The lungs showed some bronchopneumonia on the left side in the lower lobe. The other organs were negative.

DR. CABOT: In your medico-legal experience has the question ever come up of the relation of bloody fluid from the spinal cord on tapping to cerebral hemorrhage?

DR. RICHARDSON: No. I have never had any experience like that. But here once in a while the question of blood comes up, and I think in some cases we find with cerebral hemorrhage bloody spinal fluid.

DR. CABOT: I have been looking up this matter here and at the Brigham Hospital. In about two-thirds of the cases of cerebral hemorrhage there was bloody fluid on lumbar puncture. So it seems to be a helpful point in diagnosis.

A PHYSICIAN: There were no lesions in the brain?

DR. RICHARDSON: No. Anatomically so far as I found there would only be the arteriosclerosis of the vessels which would shut off certain areas from time to time with partial recovery, until finally one broke.

A PHYSICIAN: Do you believe that was claudication or a temporary thrombosis.

DR. CABOT: There is a gentleman named Pal whose book I abstracted in my Differential Diagnosis, who wrote a very interesting monograph on what he called *Gefasskrise*, or vascular crises, which he believed to occur in the brain, heart, kidney and peripheral arteries. He believed in the brain they were the cause of such things as went on here, that the vessels shut down and then relaxed; in the heart they were the cause of some cases of angina pectoris; in the kidney of some cases of temporary suppression such as occurred here, and in the extremities he believed, as everyone else does, that they were the cause of claudication. It is a good theory that nobody can ever upset. The only

positive evidence he has is this: on some occasions during an attack believed to be one of vascular spasm, an oculist looked into the eye and saw an arterial spasm which he later could identify as having relaxed again. We know that this thing happened in the retina. If it happens in the retina it might happen elsewhere. Then the point that blood pressure suddenly rises during these attacks would indicate a tightening up of the arteries.

A PHYSICIAN: That would almost seem to mean great activity on the part of the musculature of the vessels, whereas in arteriosclerosis the musculature is found to be impaired, is it not?

DR. CABOT: There is a beautiful old conception of "irritable weakness" in which an organ or a person because he is so weak becomes irritable. It is a very useful conception, and I cannot see any reason why it should not be true. Like the other, nobody can disprove it. We can imagine that an artery, becoming weak, just because it is weak is liable to explode, overact, just as a muscle overacts sometimes, or a person overacts in temper, or various parts of him. There are analogies in various parts of the body.

A PHYSICIAN: Looking at sclerosed vessels, they do not look like things that could easily shut down.

DR. CABOT: I have had trouble with that part of the conception myself.

DR. RICHARDSON: They might not shut down in the region of the marked area of arteriosclerotic degeneration but near it.

DR. CABOT: It might be that in a place that was not degenerated the same disease led to an irritability which was expressed in shutting down.

REPORTING NOTIFIABLE DISEASES.

Dr. Ralph N. Greene, State Health Officer, recently addressed the Florida profession concerning the Reporting of Notifiable Diseases. The matter is of sufficient importance to warrant reproducing in the columns of *THE JOURNAL*. The reply letter of Dr. Gordon Stanton, of Hastings, reflects what

should be the attitude of the entire profession. The two letters follow—they warrant the careful perusal of our readers:

FLORIDA

STATE BOARD OF HEALTH

RALPH N. GREENE, M. D., *State Health Officer*
EXECUTIVE OFFICE, JACKSONVILLE

AUGUST 14, 1920.

DEAR DOCTOR—In which class do you belong? The following table shows you just how many doctors are reporting notifiable diseases and the extent of their cooperation. You will note that 177 doctors sent in only one case report during the first six months of this year. 133 doctors sent in two case reports, or the equivalent of one case each quarter. Fourteen doctors in the state reported over one hundred cases each.

<i>No. cases reported January to July, 1920</i>	<i>No. of doctors in each class</i>
1	177
2	133
3	92
4	71
5-9	208
10-24	169
25-49	61
50-74	29
75-99	12
100-199	14
200-299	4
300-399	2

We have a list showing 1,450 doctors in the state, and of this number 1,000, or 69 per cent, have reported at least one case during the period mentioned.

It is very important that the State Health Officer be informed as to where and when communicable diseases occur, and your cooperation will be very much appreciated.

Every physician has been supplied with morbidity report cards (Form V. S. No. 124) which require no postage, and also with self-addressed envelopes to be used when reporting venereal diseases or other diseases which you wish kept confidential.

A report addressed to the Collaborating Epidemiologist will reach the State Health Officer.

Morbidity reports are compiled each week and if a copy will be of any service to you, just request your name to be placed on the mailing list.

Very truly yours,

RALPH N. GREENE, *State Health Officer*.

[COPY.]

GORDON STANTON, M. D.,

Hastings, Florida.

State Health Officer, Jacksonville, Fla.:

DEAR DOCTOR—In reply to your circular letter of the 14th inst., it gives me pleasure to state that I belong, I am quite sure, in either the last column No. 2, or last but one No. 4; columns 12 and 11, respectively, which reference to your index cards will doubtless show.

Since the need of this data is obvious, and your request has taken the form of an appeal rather than coercion and threats, it seems to me that all physicians should gladly impose upon themselves the rather slight burden of complying; if for no other reason than the selfish one that to be led is more agreeable than to be driven.

While I will not venture the assertion that all regulars make these reports, I wish to suggest that it is probable that these failures are enhanced by the number of irregulars, off colors—in fact, many who have no status, legal or otherwise. The knowledge of this state of affairs, and the failure of every legal effort to correct it, has made many ethical and right-thinking alopaths apathetic in this particular. This, however, is faulty reasoning, since the State Board of Health has no power to correct it.

I have the honor to enclose, herewith, the information sought by the collaborating epidemiologist of the P. H. S. relative to the malarial situation at this point.

Yours very truly,

(Signed) GORDON M. STANTON.

PROPAGANDA FOR REFORM.

ECHITONE AND ECHINACEA.—A circular entitled "Skin Lesions of Unknown and Uncertain Origin," sent out by Strong, Cobb & Co., is devoted to the exploitation of "Echitone," stated to contain echinacea, blue flag and pansy. Several years ago, the Council on Pharmacy and Chemistry examined "Echitone" and rejected the product because unwarranted therapeutic claims were made for it, and for other reasons. The drug

echinacea has been claimed to be a "specific" for rattlesnake bites, syphilis, typhoid, malaria, diphtheria and hydrophobia. It has also been credited by enthusiasts with curative effect in tuberculosis, tetanus and exophthalmic goiter, and with the power of retarding the development of cancer. The Council on Pharmacy and Chemistry examined the claims made for this drug, and reported that there was no reliable evidence in substantiation of the claims made for it. Echinacea is one of the many vegetable drugs introduced by the eclectics without a rational basis for their use. (*Jour. A. M. A.*, July 17, 1920, p. 193.)

SILVER SALVARSAN.—According to a report of the Medical Research Committee of Great Britain, silver salvarsan is apparently a molecular combination of arsphenamine and silver in some form. The substance is on trial, and its promiscuous use at this time would be ill advised. In the United States no license for the sale of silver salvarsan has been granted by the Treasury Department, and hence it may not be sold in interstate commerce. (*Jour. A. M. A.*, August 28, 1920, p. 626.)

MORE MISBRANDED NOSTRUMS AND DRUG PRODUCTS.—The following products have been the subject of prosecution by the federal authorities under the Food and Drugs Act: Tonic Remedy, a nostrum of the alcoholic type, was misbranded because the label failed to show the quantity or proportion of alcohol present. Big G., said to be "A Compound of Borated Goldenseal," was essentially a watery solution of boric acid and berberin. Plantation Sarsaparilla consisted essentially of potassium iodid, alcohol, plant material, sugar and water. Magic Eye Salve consisted essentially of zinc oxid, benzoic acid and petrolatum. Femenina consisted essentially of alcohol, sugar, water and unidentified material, with indications of valerian. Balsam Copaiba, Salol Compound, and Methylene Blue Compound (The Evans Drug Mfg. Co.), were capsules which were below standard in strength and purity.

Pabst's Okay Specific consisted essentially of volatile and fixed oils, plant extractives, including cubebs, balsam of copaiba and buchu, and more than 29 per cent of alcohol. Liebig's Diarrhoea Cordial consisted essentially of a solution of morphin sulphate, catechu, tannin, oil of cassia, oil of peppermint, sugar, alcohol and water. (*Jour. A. M. A.*, August 28, 1920, p. 623).

DIGITALIS THERAPY.—Thanks to the development of appropriate methods of physiologic assay, digitalis preparations can now be evaluated in terms of their real potency, and products can be prepared which are stable and constant as the pharmacopœial standards demand. Physicians have learned, largely through the leadership of Cary Eggleston, how to estimate digitalis dosage on the basis of body weight. As the possibility of overdosage can be recognized by the occurrence of symptoms such as nausea, or by the electro-cardiograph, it becomes possible to push the dosage speedily to the limit of tolerance, with corresponding therapeutic advantage. There remains, however, the important need of differentiating more clearly the patients for whom digitalis is actually indicated. (*Jour. A. M. A.*, August 1, 1920, p. 411.)

INTERNAL AND EXTERNAL ANTISEPSIS.—Despite the numerous efforts to demonstrate the efficacy of this or that chemical agent or drug as a gastrointestinal antiseptic, the outcome has been that the supposed benefits were due to catharsis in most instances rather than to any real effect upon the bacteria in situ. Similarly, J. F. Norton, in an investigation made for the Council on Pharmacy and Chemistry, has shown that the value of "antiseptic" and "germicidal" soap depends on the soap and not on the antiseptic or germicide contained in them. In fact, ordinary toilet soap and the green soap used by surgeons was more efficient, evidently because the added antiseptics and germicides interfered with the lathering qualities of the soap. (*Jour. A. M. A.*, August 14, 1920, p. 478.)

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"FLORIDA SPECIAL" TO LOUISVILLE.

The Fourteenth Annual Meeting of The Southern Medical Association will be held at Louisville November 15-18. On account of a little "horse play" the officers of the Association were compelled to change the date of the meeting from that originally announced. However, this in no wise will interfere with what is undoubtedly going to be the most successful meeting the Southern Medical Association has ever held. All of their meetings have been good, but the Fourteenth Annual is going to be the best ever.

For the past many years there has always been a good delegation representing the Florida Medical Association at these meetings; there has, however, been no special effort made toward the Florida members getting together either during the sessions or en route. This feature was discussed by a number of the Florida men present at the Asheville meeting last year and again at the New Orleans meeting of the American Medical Association last April. The officers of the State Association have therefore decided to run a "Florida Special" to the Louisville meeting. This will leave Jacksonville the evening of November 14th, the exact time of departure to be announced later. The "Florida Special" will be routed over the Southern Railway from Jacksonville to Chattanooga, the Cincinnati-New Orleans and Texas Pacific from Chattanooga to Danville and the Southern from Danville to Louisville. All local surgeons of the various railroads in applying for transportation should request to be routed to Louisville in this manner. Individuals purchasing tickets should see that their tickets are made out to comply with the above routing.

To insure personal comfort while in Louisville, hotel accommodations should be reserved at once. A list of the hotels, together with the various "Hotel Headquarters," was published in the August issue of *The Southern Medical Journal*. To assure ample Pullman accommodations for all journeying by

Next Meeting—Pensacola—May, 1921

the "Florida Special" to Louisville next November, all physicians residing in Florida, whether or no members of the State Association, expecting to attend the Fourteenth Annual Meeting of the Southern Medical Association in Louisville are requested to communicate at once with Dr. Graham E. Henson, Secretary, The Florida Medical Association, 335 St. James Building, Jacksonville.

G. E. H.

CASE RECORDS FROM THE MASSACHUSETTS GENERAL HOSPITAL.

Through the efforts of one of our collaborators (R. H. McGinnis), THE JOURNAL has secured authority from the Superintendent of the Massachusetts General Hospital to publish each month one of their Case Records. These Records have been published for the past several years, being edited by Drs. Richard C. Cabot and Hugh Cabot. A large number of physicians throughout the country have for some time subscribed to these Records. They are all most interesting and instructive and THE JOURNAL considers it a distinct privilege to be allowed to print them in its columns, believing that the pages devoted thereto will prove most popular with its readers and necessarily instructive. The first of these Case Records was published in the July issue of this organ. Editorial comment was crowded out of that number, but many expressions of appreciation have been received by THE JOURNAL from its readers with the hope that these Records would become a regular feature. The second of the series appears in another column of this issue and we hope will remain a permanent feature of future numbers.

G. E. H.

A STATE DIRECTORY.

With the large number of physicians settling in Florida and the general re-alignment since the close of the war there has been created a demand for a classified physician directory of the state. THE JOURNAL has been importuned by many to incorporate

this feature in its advertising columns and a decision has been made to do this providing a sufficient number of the physicians of the state patronize the pages devoted to such a purpose. It is believed that such a directory will fill a distinct need, not only to those located in the larger places and engaged in special work but also to those engaged in general work in the smaller places.

It will be the policy of THE JOURNAL to insert all cards alphabetically. Later the names may be grouped under the separate towns—these to be arranged alphabetically. A nominal charge of three dollars a quarter will be made. The cards should simply state the name—specialty, if any—location, office hours and telephone number. It is hardly necessary to state that these columns will only be open to members of the association in good standing. All desirous of inserting cards in this classified column should mail them at once, together with subscription of three dollars, to cover the first quarter.

G. E. H.

IMMUNIZATION AGAINST PLAGUE: AN ARGUMENT FOR CONTROLLED EXPERIMENTS.

The reiterated plea of scientists for accurately controlled experiments in the determination of the value of measures adopted against disease may seem to some physicians to be somewhat too emphatic. Again and again, however, the disinterested scientist is compelled to protest against the use of statistics and experiments by those commercially interested and by over-enthusiastic advocates of the prophylactic use of certain products. How difficult it really is to arrive at definite conclusions relative to the efficacy of many such preventive measures is pointed out by Flu,⁹ in a recent discussion of experiments on immunization against plague. The reports concerning the results of vaccination against this disease have been contradictory. Haffkine believed that he had demonstrated

⁹ Flu, P. C.: Experimental Immunization Against Plague, Mededeel. v. d. Burgerl. Geneesk. Dienst in Nederlandsch Indie 8:18, 1919.

statistically that his vaccine was effectual in creating immunity. Bitter and other observers, analyzing the work of Haffkine, concluded that the immunity acquired was not of high degree and that it did not last more than six months. That opinions based on statistics may not be reliable, Flu illustrates by the recital of an incident occurring in the Division of Malang in Java:

"During the epidemic in the Division of (Malang (Java)), when thousands of plague cases were occurring monthly among the inhabitants of kampongs and desa's, only one single case of plague occurred among the soldiers of the garrison in the capital of Malang, being a thousand strong, in the four years the plague was raging there. This one case was a man with a bubo in the neck who had not been infected at the barracks, as could be ascertained almost absolutely. If at the beginning of the epidemic the garrison at Malang had been vaccinated against plague, and if the results of that measure had been judged by comparison between the numbers of plague cases among the vaccinated soldiers and among the inhabitants of Malang, then this single isolated case among the former compared to the many thousands among the latter, apparently would prove for the advantage of the vaccination. This conclusion, however, would not be admissible, for a local investigation would show that the soldiers in Malang are living under much better and more hygienic circumstances than the best situated inhabitants of the kampong. The fact that the soldiers were not attacked would prove being due not to the vaccination but to the favorable conditions in the barracks, that exclude a tight contact of man and rat.¹⁰"

Flu is able to recite other instances in which incomplete reports of plague epidemics might well be cited as strong evidence of the efficacy of the various measures employed in prophylaxis. One example is an epidemic that occurred in the *desa* (village)

of Sempal Wadak in Malang, a place of about 1,700 inhabitants, in which a large sugar factory is situated. At the time of the epidemic, there were about fifty European assistants, and about 300 native laborers employed there:

"In the *desa* the plague was raging most heavily, 80 cases occurring there during three months. Suppose, that the Europeans had had themselves vaccinated against plague with *f. i.* [for instance] HAFKINE vaccine, and that by their influence they had persuaded the natives to have done the same. Now, if only was [it were] mentioned how many people were vaccinated at Sempal Wadak and how many not, and if further was said that among the Europeans only one single case of plague occurred, while among the native labourers of the factory two cases occurred against 80 cases among the not vaccinated inhabitants of the *desa*, it would wrongly appear as if the vaccination had been of excellent service. Really, these figures would not prove anything. For the Europeans were living in houses that were well protected against visits of rats and were built ratnestproof. Also the labourers of the factory came up to the requirements ordered by the house-improvement service. The only European infected had had to stay in a village-house, his own house being repaired: during his stay in the not improved village-house he was infected."

Because of such instances as these, epidemiologists have begun to be skeptical concerning statistics that are cited without the presentation of all the details necessary for an accurate judgment. The many factors entering into the causation of disease: age, sex, race, social status, occupation, residence, hygiene, house conditions—all have a definite influence. It is only by careful and repeated consideration and the employment of numerous controls that the relative importance of each factor can be estimated in any degree approaching accuracy.

As a result of his consideration of the subject, Flu determined that the only experiments on plague that can be considered of

10. The periodical from which this quotation is taken is published in Java; each page contains two parallel columns, one Dutch, the other English. The English is not always strictly grammatical, as will be noted from the portions cited.

any real value are those on animals, since it is impossible to secure perfectly controlled conditions in such work on man. Experiments of this kind he carried out in great detail, using large numbers of animals. Of all the vaccines examined, only the aqueous extracts were found to have any definite immunizing power. However, as only a low percentage of immunized animals survived injections with large doses of bacteria, he concludes that the expectation that in the course of time some method of immunization against plague may be found which will be effective in 100 per cent. or even 90 per cent. of the cases treated is at present absolutely in vain. That this is the case is supported by the fact that even a natural infection of this disease is not capable of conferring definite immunity.—(*Jour. A. M. A.*, June 19, 1920.)

USE OF ARSENIC PREPARATIONS IN TREATMENT OF SYPHILIS.

TREASURY DEPARTMENT
BUREAU OF
THE PUBLIC HEALTH SERVICE

WASHINGTON, June 5, 1920.

To the Editor, Journal of the Florida Medical Association, Jacksonville, Fla.:

SIR—On account of the large number of arsenic preparations which are being exploited for the treatment of syphilis, the United States Public Health Service has considered it desirable to issue a circular letter, copy of which is inclosed, discouraging the indiscriminate use of untried preparations.

Attention is especially invited to the fact that provision is made for the experimental use of any preparation under conditions which will make the results of such experiment available to others than the physician immediately concerned.

I shall be glad to have you give the circular letter and this letter of transmission publicity.

Very truly yours,

H. S. CUMMING,
Surgeon General.

TREASURY DEPARTMENT
BUREAU OF THE PUBLIC HEALTH SERVICE
WASHINGTON

May 12, 1920.

BUREAU CIRCULAR.

LETTER No. 219.

Medical Officers, U. S. Public Health Service and others concerned:

Your attention is invited to the extensive exploitation through advertisements in professional journals and otherwise of various arsenic preparations which are not related to the arsphenamine group. The preparations referred to are sold with claims in regard to their value in the treatment of syphilis, which are unwarranted.

In the opinion of this office it is in the interest of all concerned that the subcutaneous, intramuscular or intravenous use of arsenic in the treatment of syphilis be confined to preparations of the arsphenamine group as these agents are of established value and are produced under the regulations of the Public Health Service. The following firms are now licensed for the manufacture of arsphenamine and neo-arsphenamine:

Dermatological Research Laboratories,
1720 Lombard Street, Philadelphia, Pa.

H. A. Metz Laboratories, 122 Hudson
Street, New York, N. Y.

Diarsenol Co., Inc., Buffalo, N. Y.

Takamine Laboratories, Clifton, N. J.

The Lowy Laboratory, of Newark, N. J., has been granted a license to prepare a stable solution of arsphenamine.

It is not the desire of the Bureau to limit clinicians in the choice of agents of recognized worth, but in the case of arsenic preparations, not members of the arsphenamine group, the available evidence indicates that their routine use is inadvisable in the treatment of syphilis. If it is desired to use any of these preparations in a purely experimental way previous authority from the Bureau should be secured. Applications for this authority should be accompanied by a statement as to the composition of the drug, including the structural formula and the

reason for its use. All information available on the value of the preparation should be forwarded.

Receipt of this circular should be acknowledged and marked "*V. D. Division.*"

H. S. CUMMING, *Surgeon General.*

PERSONAL NOTE.

Dr. Ralph N. Greene desires to announce that he has been compelled to withdraw from the Diagnostic Staff connected with Dr. Marvin Smith's Sanitarium. Dr. Greene found that the work entailed on the staff conflicted with his duties as State Health Officer.

The annual convention of the National Anæsthesia Research Committee will be held in Pittsburg the week of October 4th, in conjunction with that of the Interstate Anæsthetists' Association and the Pennsylvania Medical Society. Prizes aggregating \$200 are offered by the society for the best papers on original research in anæsthesia, such papers to be read at the annual meeting. This offer is open to all surgical, medical and dental students, and practitioners in the United States.

NEW AND NONOFFICIAL REMEDIES.

BENZYL BENZOATE-FRITZSCHE.—A brand of benzyl benzoate (see *New and Nonofficial Remedies*, 1920, p. 49) complying with the N. N. R. standards. Fritzsche Brothers, Inc., New York.

BENZYL BENZOATE-MERCK.—A brand of benzyl benzoate (see *New and Nonofficial Remedies*, 1920, p. 49) complying with the N. N. R. standards. Merck & Co., New York.

BENZYL BENZOATE-ORGANIC SALT AND ACID CO.—A brand of benzyl benzoate (see *New and Nonofficial Remedies*, 1920, p. 49) complying with the N. N. R. standards. Organic Salt and Acid Co., New York.

DIPHTHERIA TOXIN-ANTITOXIN MIXTURE (GILLILAND).—Each cubic centimeter of diphtheria toxin-antitoxin mixture (see *New and Nonofficial Remedies*, 1920, p. 264) represents three lethal doses of toxin and approximately 3.2 units of antitoxin. Marketed in packages representing one immunizing treatment, and in packages containing ten treatments. Gilliland Laboratories, Inc., Ambler, Pa.

PUBLISHER'S NOTES

THE THERAPY OF ADRENALIN.

The important position of Adrenalin in the materia medica is undoubtedly attributable to the vast amount of scientific work that has been done in connection with the product, to say nothing of the marvelous array of clinical facts that have been accumulated and now constitute the basis of our knowledge of its therapy.

This thought is suggested by the appearance in our advertising section, this month, of a unique announcement from Parke, Davis & Co. entitled "*Adrenalin in Medicine,*" which every medical practitioner should read. It deals with the physiological action of the medullary suprarenal principle and reflects a clear light upon a subject concerning which much misinformation persists, even in medi-

cal circles. This, we understand, is the first of a series of short essays that will have to do with the scientific aspect of the subject rather than its commercial features. Others will include discussions of "*The Treatment of Asthma*"; "*The Treatment of Shock and Collapse*"; "*The Treatment of Hemorrhage*"; "*Adrenalin in Combination with Local Anesthetics*"; "*Adrenalin in Organotherapy.*"

These topics appeal strongly to the progressive physician who seeks to be well informed. New facts are being constantly developed in the domain of endocrinology; and as this series of concise "talks" will cover the field pretty thoroughly, insofar as Adrenalin is concerned, it will be well worth while to review them.

BLOOD CHEMISTRY

Blood Sugar . Creatinine . Creatine . Uric Acid . Urea

Joslin states that the frequency of diabetes in the United States is *one per cent of all individuals* (they either have the disease or will develop it); also that the frequency of diabetes in a community may be the index of the intelligence of its physicians.

Cited by Gradwohl and Blairas, The Newer Methods of Blood and Urine Chemistry, The C. V. Mosby Co., St. Louis.

THE WASSERMAN TEST

While probably the vast majority of cases of syphilis can be diagnosed clinically, no case can be scientifically treated without employing the Wassermann test to note the progress of the case.

AUTOGENOUS VACCINES

In certain selected cases an autogenous vaccine secures results not obtained with stock vaccines.

For further information address:

DOCTOR GRAHAM E. HENSON,
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DR. GERRY R. HOLDEN ANNOUNCES

TO THE MEDICAL PROFESSION THAT HE IS
PREPARED TO GIVE RADIUM TREATMENT IN
ANY OF THE VARIOUS PATHOLOGICAL CON-
DITIONS WHICH ARE AMENABLE TO RADIUM
THERAPY.

513 LAURA STREET
JACKSONVILLE, FLORIDA

ORIGINAL ARTICLES

HEMATURIA.*

J. CLIFFORD VINSON, M. D.,

Head of Section on Urology and Dermatology, Division of Surgery, Bayside Hospital, Tampa, Fla.

Hematuria should be defined as bleeding, either microscopically or macroscopically, occurring in the urological tract, directly or remotely connected with the urinary act. Bleeding may occur intermittently or continuously either with or without pain.

The causes producing this symptom are numerous, and bleeding occurs as a result of trauma or with any diseased condition of the urological tract. It may occur as the result of acute general infection, peculiar conditions of the blood, and occasionally by the ingestion of certain drugs. The bleeding occurs in the anatomical zones and is divided into kidney, ureter, bladder, prostate and urethra.

A few of the more common causes producing bleeding as a symptom are: Trauma, calculus, tumors, tuberculosis, nephritis, embolism, and infarct of the kidneys, thrombosis of the renal vessels, arteriosclerosis of the renal vessels, syphilis, cystitis, prostatic hypertrophy, carcinoma of the prostate, protozoa, acute and chronic urethritis, and foreign bodies.

Hematuria never occurs without a cause, and it is the duty of the physician to see that adequate measures are instituted to find the source of the trouble. It is not an infrequent occurrence for the patient to admit that blood in the urine has been present from time to time over a period of years, and unfortunately a number of these patients have died as a result of the procrastination of the physician, or his inability to appreciate the seriousness of the symptom.

Ninety-eight consecutive cases were collected from the reports of our clinic. All cases so collected showed gross bleeding and no case of acute or chronic urethritis was included. The cases have been grouped anatomically and the lesion listed under these headings are placed in the order of frequency.

First, Renal:	
Calculus	10 cases
Nephritis	8 cases
Pyelitis	7 cases
Pyonephrosis	4 cases
Hypernephroma	3 cases—37
Second, Ureter:	
Calculus	13
Third, Bladder:	
Papilloma	10 cases
Calculus	8 cases
Tumors, malignant	6 cases
Foreign bodies	2 cases—26
Fourth, Prostate:	
Hypertrophy, simple	11 cases
Hypertrophy, malignant	6 cases—17
Fifth, General:	
Filaria	3 cases
Myelogenous Leukemia	1 case
Bichloride of Mercury	1 case — 5
Grand total	98

The age extremes were six and eighty-one years, and there were 24 females and 74 males. Bleeding had been noticed by the patients for from one week to eleven years. Calculus and malignant tumor lead in frequency, calculus occurring in 31 cases, or 31.6 per cent, and malignant tumor occurring in 15 cases, or 15.3 per cent. Papilloma occurring in 10 cases, or 10.2 per cent. When you realize that the tumors grouped under the heading of papilloma are always potentially malignant you can readily appreciate the seriousness of the high percentage of neoplasm.

A study of the three cases of hypernephroma is interesting. In two cases hematuria had occurred intermittently for from five to seven years respectively. In the first case the patient had been under the care of a physician for four years without a diagnosis having been made—the presence of a hyper-

*Read before the forty-seventh annual meeting of The Florida Medical Association, at Daytona, May 12-13, 1920.

nephroma was not suspected until relief was sought for a tumor in the right upper quadrant. The tumor proved to be an extension of a right side hypernephroma. The case was inoperable and died within a few weeks.

In the second case the hematuria had occurred intermittently for five years. The patient was constantly attended by physicians, and in the endeavor to cure their patient a number of queer measures were instituted. It is needless to state that most of his teeth had been removed. Through neglect of adequate study the diagnosis was not made until the case was hopeless.

The third case, sixty-five years of age, was referred to me by Dr. Ernest J. Brecht, of Ft. Myers, April 20, 1916. Family history negative. He had been perfectly well until six months previous, at that time noticed blood in the urine for three or four days unaccompanied by pain. Has had three attacks. The last attack began ten days ago and the bleeding has continued. The patient complained bitterly of bladder irritation.

General examination was negative. A large number of blood clots were washed from the bladder. Cystoscopic examination demonstrated a normal right kidney, and a bleeding left kidney. X-ray examination showed an enlarged irregular kidney outline, with a pronounced tumor-like irregularity near the center of the convex border of the left kidney. The kidney was removed and pathological study by Dr. H. F. Mills demonstrated hypernephroma. No metastatic growth was found and since the operation semi-annual examinations have failed to disclose a reoccurrence in any part of the body.

Even a casual study of these figures will impress upon the physician the futility of medication, and the immediate adequate study of cases presenting hematuria as a symptom.

Conclusions.

First.—The importance of hematuria as a symptom.

Second.—The high percentage of malignant tumors presenting hematuria as a symptom.

Third.—The necessity of early appreciation of hematuria as a means of preventing malignant growth, and

Fourth.—The necessity of adequate study and diagnosis of all cases presenting hematuria as a symptom.

OBSTETRICS AS RELATED TO HYGIENE, THERAPY, AND SURGERY.*

C. D. ROLLINS, M. D.,
Jacksonville, Fla.

There is no branch of medicine which is practiced with such a varying degree of efficiency or inefficiency as obstetrics. It may be classed, in accordance with the manner in which it is practiced, as a trade, a science or as a profession. Whatever its classification, it is the oldest of its kind. At its beginning it followed the rule of an instinctive hygiene and the results were good because the human race lived close to nature and the follies of fashion did not interfere with natural laws.

When physical imperfections began to show themselves in women, surgical and therapeutic assistance became necessary, and as the artificialities of life increased and the burdens borne by girls and women grew heavier, the necessity for more attention to obstetrics became evident. The obstetric forceps, ecbolics and analgesics were born as the children of this necessity; but the necessity is still alive, for obstetrics is not an exact science in theory or practice. Many are the bad or even fatal results to mother or child attendant upon the act of parturition, even in this day, and these "Tragedies of Obstetrics" should stir us to enlist our most careful consideration of the cases of pregnancy under our care. It is a safe policy to view every pregnant woman as a doubtful risk in whom any complication may arise at any time of pregnancy. For the sake of the child, also, and its posterity, we should safeguard

*Read before the forty-seventh annual meeting of The Florida Medical Association, at Daytona, May 12-13, 1920.

the mother and keep her the most healthful and vitalizing host possible. To be well born, one must start generations back, but as we only figure in the improvement of the animal vitality of the lives we deliver into the world, we should start our work when pregnancy starts. At this time a woman undergoes a great change and starts life in a different direction. The change is due to the reaction of the maternal organism to the growing ovum. While this is a physiological process, pathological conditions may arise, as the result of pathological lesions which were already present before pregnancy began. For instance, focal infection in teeth, tonsils, sinuses, appendix, urinary or pelvic organs, or gall bladder, may be the pathological lesion from whence arises the intoxication which interferes with the normal metabolism in the mother and sets going morbid conditions which are very potent factors in the final outcome to mother and child. Such foci of multiplying bacteria is, probably, the important first cause of imperfect metabolism and the presence of undermetabolized products in the pregnant woman, as well as responsible for the presence of bacteria in her circulating blood.

Warnekros obtained 18 positive blood cultures out of 25 cases, blood taken antepartum in toxemic women. The streptococcus is prominent among the kinds of bacteria recovered by him. In consideration of the fact of the apparently selective damaging effect of streptococci on the kidney perenchyma, as illustrated by scarlet fever, and upon the villus membrane, as demonstrated by the frequency of uterine hemorrhage and miscarriage in toxemia of pregnancy, does it not seem very significant that streptococci are the predominating bacteria in chronic tonsillar and teeth abscesses? Likewise, pathological processes in the liver or near enough to disturb the nerve supply or circulation of the liver, might so disorganize its function that the system is intoxicated with insufficiently oxidized proteins. The pregnant woman's metabolic requirements are greater, on account of the growing fetus and the general

plethora, with increase in volume of blood; hence, the greater amount of these toxins to be eliminated.

In the effort of the kidney to eliminate these undermetabolized products and insufficiently oxidized proteins, together with the excreta of the fetus, it is overworked and we have, as the result, "THE KIDNEY OF PREGNANCY," a kidney insufficient to eliminate its share of the toxic material being formed in the body. The present view is that the kidney of pregnancy is caused by the same toxemia of pregnancy which causes eclampsia, but the kidney of pregnancy is usually produced first, and then is contributory to the eclampsia. The kidney becomes more damaged as it continues the effort, and becomes progressively more inefficient. This kidney of pregnancy when it comes to the pathological laboratory is large, pale, soft and cloudy, anemic or yellow in color, and microscopically shows fatty changes in the glomeruli and tubules, and is undoubtedly a pathological kidney. With such a kidney, and no restrictions as to work thrown upon it, and no efforts to increase the skin elimination, complete systemic intoxication necessarily follows and finally increases to the eclamptic stage.

Our efforts in the treatment of the eclampsia as well as the kidney of pregnancy, is primarily a matter of hygiene:

Liver cleaning, intestinal tract cleaning, skin cleaning, and blood cleaning. We discontinue certain kinds of food which overtax the patient's metabolic and oxidizing capabilities, and allow a chance for rest of these organs. Our relation to therapy is here demonstrated and the correct drug harmonizes our treatment and helps us to succeed. And without surgical aid also, in some cases of eclampsia, it might be like the kingdom that was lost for the want of a horseshoe nail.

From my eclamptic cases which involved surgery, I will report one to illustrate the unity of my subject: A multipara in the ninth month of pregnancy had been having convulsions for several hours. When first seen coma was profound, without intervals

of consciousness. However, she was extremely restless, taking two people to restrain her. Blood vessels were very tense. She had been given two doses of croton oil without any effect. The case seemed very urgent. Did not take time to move her to the hospital, but immediately put her on a table in the house and after she had been given enough ether to arrest the convulsions, and quiet the nervous symptoms, I began to dilate the cervix. Inserted one finger into the cervix, then two, finally three and when dilated sufficiently, inserted large Voorhee's bag and filled the bag with sterile water. By traction on the bag, with the patient under light anesthesia, the uterus was made to contract at intervals and cervix was soon dilated sufficiently to expel the bag. Dilatation was continued. At this stage the fetal heart was becoming very slow. In about 40 minutes, after repeatedly listening for the fetal heart, it became inaudible and the fetus showed no sign of life. As the indication was for haste, and the cervix sufficiently dilated by this time, craniotomy was done; axis traction forceps applied and delivery completed. She did not bleed as much during delivery as was hoped. She was put to bed and measures for elimination by skin and intestines were started. Heat was applied to the body; the stomach was washed out with solution of sodium bicarbonate, and 10 grams of calomel put into the stomach with a tube. Five hours later, patient showed no improvement, and was in absolute coma, completely overwhelmed by the enormous amount of toxic material in her system. No movement had taken place from bowels or kidneys. The abdomen was ballooned up to an enormous degree, and there was complete bowel stasis. Eserine sulphate was given hypodermatically every hour, hoping to start peristalsis of intestines. This drug, and 10 grains of calomel, were the sum total of therapy in the case. Both, I believe, were parts of the ensemble which brought this case through what bid fair to be a fatal case of eclampsia. At the second visit, the patient was worse than before the uterus was emptied. I hurried her to the

hospital and did venesection, removing about 350 c. c. of blood and instilled in the vein 1,400 c. c. of normal salt solution. After about 700 c. c. had passed into the vessel, the patient began to sweat most profusely, and by the time we were through, the blanket around her was thoroughly wet, the sweat ran from the pores of her skin and dripped on the floor. She was then put in a hot bath, being suspended in the bath tub, in absolute coma, and rubbed vigorously by attendants for 30 minutes. She was then put to bed and let alone except for her hypodermics of eserine sulphate. In about six hours she showed signs of returning consciousness, and in eight hours bowels and kidneys acted. I believe she voided in the bath. She was given salt solution by hypodermoclysis for several days. This case went on to complete recovery and is now apparently very healthy. It is possible that hygiene and diet might have averted this eclamptic seizure and saved the child. When toxins have accumulated to the amount evidenced in this case, it requires the best there is in therapy, and surgery, to save the patient.

Hygiene figures greatly in normal obstetrics, and is a potent factor in keeping obstetrics normal. Abnormal, or pathological obstetrics brings us in relation with therapeutics and surgery. To understand our relation to these branches, and to know when to resort to surgery, or therapeutics, we must know normal obstetrics. How can we judge of the abnormal and pathological if we do not know the normal? We must know the natural laws involved in the act of parturition. Knowing the size, shape, and capacity of the birth canal we are dealing with, the number of babies we have to deliver, and the position and presentation, we will be in a position to treat the case intelligently, especially if it is a classically pathological case. It is the border line cases which are the most difficult of diagnosis, and require careful weighing of all the conditions which are opposed to a normal delivery, and of the forces which will operate to overcome the difficulties. Then, judgment as to whether

these forces will be sufficient to compensate for the increased difficulties. Some cases which at first examination appear to be serious disproportions, will mould and adjust and advance, if the uterine power is sufficient, or if it is urged with small doses of pituitrin, at frequent intervals, hypodermatically. Of course we must be absolutely sure that the advance of the fetus is not hindered by its own manner of presentation or by the presence of a tumor. Patience is a virtue with these kinds of cases in these hurry-up days. It is wonderful how some of these border line cases will work themselves out of the difficulties without surgical intervention. We should pursue a patient, watchful policy, assisting the natural forces with pituitrin and strychnine and preventing shock and exhaustion by the intelligent use of analgesics. The patient should have relief from exhaustion and shocking pain by use of morphine-scopolomine, nitrous oxide, and oxygen, separately or in conjunction. I believe that women should be spared the suffering of childbirth as near as it is possible, and there is a great deal which we can do in that line. When we learn to individualize our anesthetics perfectly, we can give every patient a painless childbirth, as much so as a painless tooth extraction can be done. Our present methods are perfectly adequate with some cases, but with others we may need other methods. For instance, blocking the nerve supply of the cervix, vagina and perineum, thus anesthetizing the origin of the painful impulses. I hope to be able to report some completed work along this line before very long.

Why is it that woman suffering during childbirth does not arouse any sympathy, but her suffering is taken as a matter of fact? The old adage that "men must work and women must weep," should be revised now as women do about as much work as men. We should, therefore, make childbirth as painless as possible, to the end that women will not dread parturition and that the effect upon them will not be so detrimental. A woman that has suffered a long, exhausting

labor, with severe pain, is in bad shape to resist infection and if she gets a laceration probably will not heal well, it matters not how carefully and correctly it is repaired. Many doctors' experiences with such cases have caused them to become discouraged and abandon repair of lacerations. Some of these bad results are due to the manner of repair, and the lack of surgical technique, but many of them are due to the breaking down of the natural defensive and recuperative forces of the body, by the exhaustion and pain of labor. The fact is, that those cases should not be allowed to drag on unnecessarily, and should not be allowed to have severe suffering. Surgery should not be resorted to for expediency, but comprehension of one's case and good judgment will guide in the decision as to when to apply forceps or when to repair. Take a case of a primipera of, say thirty years old, giving birth to a large child. The cervix and perineum are unyielding and dilation is slow and extremely painful. Say pains began at 3 a. m. and continued all day, growing unbearable by night as she becomes threadbare and exhausted. This patient needs rest and sleep, or forceps under anesthesia. But instead, the flagging uterus is whipped up with large doses of pituitrin. Pain becomes spasmodic and violent and the patient suffers torture, but is finally delivered with a bad laceration of the perineum. The patient is shocked, exhausted, and has a torn perineum. She is extremely nervous and miserable; her vitality is temporarily gone. Her bodily resistance broken up. The efficient defense against infection and the recuperative quality of tissue is the natural defense and vitality possessed by the body. The resistance to infection at the time of labor, and the power to recuperate, is influenced more by the condition of the patient when she comes into labor, and the amount of pain and shock as result of same, than upon anything we can do for her in therapy and surgery. Good results, therefore, in these cases depend not alone on a good surgical delivery and repair, nor upon our therapeutic treatment of the damage done to the nervous

system by the pain of labor, but upon the condition in which you have brought the patient to the hour of delivery, together with the ease and comfort in which you bring her through the ordeal. Efforts to have patients reach the day of parturition in the best possible shape, is part of the hygiene of pregnancy. Patients therefore should be examined and instructed regularly. Our object is to store up vitality in the tissues so that we will have less trouble during labor and the puerperium, and not allow our store of vitality to be dissipated by prolonged suffering during labor. The late war experiences with surgical wounds have corroborated our findings in regard to obstetrical wounds and infections. Hundreds of cases at the front proved that no matter how favorable the wound appeared to be, primary union could not be secured if the patient was in deep shock, in great exhaustion from cold and hunger, or overexertion from fighting. When one is in shock or exhaustion the local tissues suffer a decline in their natural defense and therefore even a slight infection causes disastrous results. A woman in labor with disproportion, a bad position, or even with rigid, soft parts, suffers more than soldier ever suffered from stab of bayonet or shock of shell. If allowed to suffer unaided, she may die under the terrible torture or she may force an exit for the child by tearing through her own perineal floor, leaving a wound in devitalized tissue, and shock and exhaustion similar to that we had to contend with in wounded soldiers. Can we not learn a lesson from war experiences and treat such lacerations as shocked and wounded soldiers were treated? First, dress the wound with acriflavine; this holds the wound in statu quo, and in twenty-four or forty-eight hours it is in the same condition for repair as a fresh wound. Then treat the shock. Rest should be given your patient, with morphine if necessary, and the tissues of the wound allowed to assume their somewhat normal biological relations, so that we can make a repair with due regard to the biology of the part, as well as the anatomy and bacteriology. Do not fail

to repair a laceration properly in twenty-four or forty-eight hours. Nitrous oxide and oxygen anesthesia is best for this, but I have done it very satisfactorily with cocain infiltration.

Speaking of anesthetics, I might say we have three so-called obstetrical anesthetics to select from: scopolamine-morphine, nitrous oxide and oxygen, and chloroform. The objection to chloroform is that it cannot be used to the extent of affording much relief from the suffering without inhibiting the involuntary muscular action of the uterus and prolonging the labor. Besides, it is not without considerable danger as an anesthetic. Scopolamine-morphine I have used with great comfort to the mother, and considerable anxiety to myself, in several hundred cases without a serious result. One baby was resuscitated with difficulty, requiring besides the usual methods, the use of atropine hypodermatically and oxygen by inhalation. Scopolamine-morphine is very gratifying for nervous patients, and if the dose and time of administration is carefully individualized, our results will be good. You can not have any routine administration or have it given in your absence. Nitrous oxide and oxygen is the safest and most practical obstetrical anesthetic which we are using at present, and the only objection to it is the expense. It is true, the perversity of pregnant woman does manifest itself occasionally with this anesthetic and she refuses to be relieved by it. Then I resort to scopolamine-morphine in conjunction. In these cases, where gas has failed to relieve, chloroform is even more inefficient, and they ask to be given gas again after trying chloroform. Anesthetics may be classified as therapy, yet in preventing shock and promoting mental repose and health, it is hygiene. We cannot classify obstetrics as hygiene, therapy, or surgery, but as it is related so peculiarly to all the sciences, its importance as a special field of research and investigation is conceded, not alone for its extensive ramifications in medical science, but because it involves the comfort and capabilities of the mothers of today and the

maturity and fitness of their sons and daughters. One to be well born must start generations back. But we cannot improve past generations, so let us start now and make the pregnant patients under our care the very best possible parturient hosts.

HAY FEVER, "ROSE COLD."

FRED J. WALTER, M. D.,
Daytona, Fla.

It is unlikely that a specific for turgescence of the mucous membranes of the upper respiratory tract will ever be found in one measure or in any one remedy, though prophylaxis and pollen antigens have a very important place. In the minds of many of us the predisposing cause is most frequently from within. Local treatment sometimes will help, though, like eczema, unless carefully studied, irritation results. The writer would direct attention to the following measures:

1. Less food and drink.
2. Regular and free elimination from the skin and bowels.
3. Warm skin. Avoid chilling of the surface.
4. Daily consistent exercise.
5. Sufficient sleep.
6. Frequent baths.

It is the firm conviction of many writers that insufficient attention is given to the quality and quantity of food taken and some may add the amount of fluids taken. As etiological factors let me add to the above list and comment in this way. The amount of albuminous foods and heat-producing foods should be limited. Iced drinks should be discouraged. Fatigue, irregular habits and late hours should be corrected. Suitable underwear to avoid chilling the surface of the body should be worn. The peninsula of Florida is favorable to hay fever patients and this is likely due to the fact that the skin is moist much of the time during the season and we have not the appetite for meats and heavy foods so desired in colder sections of the world. We do have pollens enough to cause trouble in those sensitive; though as a rule hay fever is light in Florida. Just as chilling of the skin will

often produce turgescence of the mucous membranes, so gentle and gradual perspiration is one of our best remedies to reduce it.

It is vitally important that these sufferers should be reasonably active a part of each day. If the occupation does not make this possible, graduated exercises should be taken up and followed consistently. Frequent and sufficient elimination of the waste products should be insisted upon. The use of fruits and vegetables are to be thought of as food and laxatives, though salines may be required occasionally. Regular and daily baths are most helpful, the temperature to be such as will favor elimination by the skin. The bath to be followed by brisk friction with a Turkish towel. Regular habits and regular hours for sleep must be regarded as essential. Let the patient hunger and thirst a bit, keeping in mind that two meals a day may be better than three. If the annual attack has not yet come on, do not overeat. If the attack has come on, reduce the amount of liquids and take two meals a day. As a local, simple and effectual measure the prolonged use of very hot sterile salt solution as a nasal irrigation (15 to 20 minutes) may be required. The good result from the latter may last several days.

PROPAGANDA FOR REFORM.

BENZYL BENZOATE.—The chemical properties of benzyl benzoate have been known for years. Its therapeutic properties as an anti-spasmodic have been known only a short time. Before this new addition to our *materia medica* can be given thorough clinical trial, it is necessary that the products be of a quality sufficiently pure for medicinal use. For the physician's protection, as well as for an aid to the manufacturer, the A. M. A. Chemical Laboratory, at the request of the Council on Pharmacy and Chemistry, has elaborated purity standards. It has also examined the market supply and found that, on the whole, the nonproprietary medicinal brands are of a satisfactory grade for clinical use. (*Jour. A. M. A.*, July 31, 1920, p. 335.)

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Next Meeting—Pensacola—May, 1921

ALL ABOARD FOR LOUISVILLE.

A sufficient number of applications for Pullman accommodations on the "Florida Special" for Louisville have been received to insure the success of the proposed movement. The special will leave Jacksonville on Saturday, November 13th, at 8.10 p. m., being routed over the Southern Railway to Chattanooga, the Cincinnati-New Orleans and Texas Pacific from Chattanooga to Danville and the Southern Railway from Danville to Louisville, the point of destination being reached on Sunday at 9.25 p. m.

The general arrangements for the meeting of the Southern Medical Association are as follows:

On Monday, November 15th, meetings of the Southern States Association of Railway Surgeons, the Southern Gastro-Enterological Association, and the Association of American Medical Mill Commissions. In addition to the meetings of these organizations, a conference on Medical Education will be held and the National Malaria Committee will be in session all day, holding both morning and afternoon meetings.

A full and interesting program will also be conducted by the Sections on Urology, Orthopedic Surgery, Roentgenology, Obstetrics, and Hospital Management.

On Tuesday, November 16th, at 9.40 a. m. the general opening sessions will be held, including addresses of welcome, orations, President's address and the reports of officers.

The Sections on Medicine, Pediatrics, Public Health, Surgery and the Eye, Ear, Nose and Throat will open for the reading and discussion of papers on Tuesday afternoon at 2 o'clock and will conduct sessions through Wednesday morning and afternoon and Thursday morning.

On Thursday afternoon, November 18th, the last General Session of the Association will be held to be followed by a General Symposium on Nephritis.

The General Headquarters and those of the Scientific and Commercial Exhibits will be at The Armory.

The Seelbach Hotel, Fourth and Walnut streets, will be the general hotel headquarters and hotel headquarters for the Sections on Medicine and Pediatrics, for the Southern Gastro-Enterological Association, and for the Conference on Medical Education.

A complete list of the hotels and hotel headquarters will be found in the August issue of the *Southern Medical Journal*.

G. E. H.

THE PROPOSED STATE DIRECTORY.

Supplementary to the editorial contained in the last issue of *THE JOURNAL* concerning a State Directory, the following letter was addressed to a number of the older members in point of service in the Association, together with as many others as are known by the writer to be engaged in special work:

DEAR DOCTOR—Your attention is invited to an editorial appearing in the current issue of *THE JOURNAL* under the caption, "A State Directory."

It is not deemed practical to address each member of the Association, so this letter is being sent to a few of the older members in point of service in the Association and to at least a majority of the members known to be engaged in special work.

For some time the undersigned has been importuned to incorporate in *THE JOURNAL* such a classified directory as is now proposed. It is of course hardly necessary to state that the pages will be conducted along strictly ethical lines. A number of the state-owned Journals have run these classified cards for a number of years, seemingly at a profit to both the organ and to the subscribers.

Whether or not *THE JOURNAL* incorporates this feature is dependent on the members of the Florida Medical Association and the views of "the old, the tried and the faithful member" are especially desired at this time.

If you approve the scheme, do you care to have your card inserted; if you do not approve, will you be good enough to write me a few lines, expressing your opposition.

With my kind personal regards,

Faithfully yours,

GRAHAM E. HENSON,
Secretary-Editor.

At the present writing *THE JOURNAL* is in receipt of several communications in favor of establishing the directory and subscribing to it, with a few opposing the suggestion.

THE JOURNAL has not at this writing, however, received a sufficient number of

replies to this letter or comment on the September editorial to be able to determine what the real wishes of the Association are. *THE JOURNAL* stands entirely neutral on the question, the scheme having been proposed by some of the prominent and active members of the Association. An effort is being made through a referendum to the Association to determine what the majority interested desire in this matter. *THE JOURNAL* will go so far as to say that having heard opinions on both sides of the question, there is considerable to be said on either side.

Readers of *THE JOURNAL*, even if not interested in inserting a professional card, are urged to express an opinion on the policy they wish adopted.

The affirmatives are more likely to make themselves heard on a question of this kind than are the negative. We, therefore, especially appeal to those who feel they have good grounds for opposing the scheme to express their opinions and not allow themselves to be outvoted by default.

G. E. H.

THE ANTIVIVISECTION INITIATIVE IN CALIFORNIA.

The public and the medical profession in California are facing a serious situation. An antivivisectionist initiative is to be voted on by the people of the state at the November election. If the majority of the voters approve the measure, it will become a law without any action on the part of the legislature or of the governor.

Even a cursory examination of the proposed legislation reveals its harmful character. If adopted, all the experimental research in general biology, in agriculture, and in general and veterinary medicine would have to be discontinued. Furthermore, the proper training of students in these essential subjects would be rendered impossible. The measure would virtually abolish in California the use of modern diagnostic methods in the practice of medicine. No Wassermann reactions, no diphtheria test for virulence, no in-

oculations to determine the presence of tuberculosis would be permitted. The preparation of vaccines and curative serums, and the standardization of drugs by animal tests could not be carried out. Many public health activities would be paralyzed. For example, the making of a positive diagnosis of bubonic plague, and the control and study of certain epidemics of food poisoning would be stopped because they require procedures prohibited by the proposed law.

The Board of Regents of the University of California and the Trustees of Stanford University have united in a public protest against the antivivisectionist initiative. A part of the statement is as follows:

The advance of sanitation, modern medicine and physiology and the teaching of biology all rest on animal experimentation. The control of epidemic diseases, the management of surgical operations and of childbirth, and the certification of milk and water supplies would be impossible without the knowledge gained by such studies. In fact, the whole structure of the present day protection of the public from disease rests upon animal experimentation.

The University of California and Stanford University are vitally interested in this initiative measure since its passage would stop the research work now going on in their medical schools, hospitals and laboratories, and in the Bureau of Animal Industry. The studies on botulism in olives, which will not only save the ripe olive industry of the state, but many lives, would cease, as would likewise the manufacture of serum for the prevention of hog cholera, the preparation of vaccine for anthrax, and the various other measures that annually save millions of dollars and prevent great suffering among domestic animals. Even feeding experiments on animals would be impossible.

No worse attack on the welfare of the state and on the right of the university to seek and teach the truth could be made. Every man, woman and child, every unborn babe, every domestic animal in the state will be affected if this measure becomes a law. It is unnecessary special legislation due to prejudice and misinformation. No one will tolerate cruelty to animals. The present laws of the state are drastic and quite sufficient to control any abuse. We know that there is no cruelty to animals in the laboratories of the universities. They are in charge of men and women of the highest character, who are unselfishly working to better the lot of their fellow men. Anesthetics are always used for animals in the laboratory in exactly the same way that they are used by surgeons in the operating room. The real object of the antivivisectionist is not the prevention of cruelty to animals, but the prevention of progress in science and medicine.

With reference to the statement that the present laws of the state are sufficient to

control any abuse, it is well to recall that in 1915, Hiram Johnson, then governor, vetoed a proposed antivivisection law, and in explaining his refusal to sign the bill, declared:

I may add that the laws of the state of California for the prevention of cruelty to animals and the punishment of those guilty are plenary. Full authority is given to the humane officer under the law, to obtain search warrants, enter premises, and gather such evidence as he may suspect exists. With our drastic laws, there can be no excuse for those who insist cruelties are practiced upon animals for permitting these cruelties to continue or those practicing the cruelties to go unpunished.

In the history of the efforts of antivivisectionists to prevent the progress of medicine by methods that have proved of the utmost value in every one of the natural and biologic sciences, this is the first time that an appeal has been made directly to the voters. Eastern antivivisection journals have called repeatedly for financial and other support for the propagandists who are working in California. The activities carried on there indicate that a large amount of money has been contributed from other parts of the United States, and that the usual distribution of misleading and harrowing descriptions of laboratory procedures, a practice so severely censured by the British Royal Commission, has been employed. A test is thus to be made of the general intelligence of the voters of California. When people are properly informed of the methods of animal experimentation, the precautions that are taken to avoid unnecessary pain, the character of the investigators, and the beneficent results that flow from medical research, there is no question that a large majority will not only tolerate, but will promote the efforts of the laboratory workers. It is of prime importance that well-informed physicians recognize the fundamental question which is presented by this legislation, and that they spend time freely to give information as to what the measure really means. The burden of responsibility is placed on the enlightened because we live in a democracy, and are ruled democratically.—*Jour. A. M. A.*

CASE RECORDS*

(ANTE-MORTEM AND POST-MORTEM) AS USED IN WEEKLY
CLINICO-PATHOLOGICAL EXERCISES AT THE

MASSACHUSETTS GENERAL HOSPITAL

EDITED FOR THE USE OF PRACTITIONERS BY

RICHARD C. CABOT, M. D., AND

HUGH CABOT, M. D.

F. M. PAINTER, ASSISTANT EDITOR

CASE 6142

An American railway engineer of thirty-nine entered December 1 for relief of abdominal pain.

F. H. His father died of heart disease, his wife of phthisis.

P. H. Nineteen years ago he was treated three weeks for gonorrhea. Seventeen years ago he was ill three weeks with "malaria." Eight years ago he had chancre, treated with cautery. Five years ago he had an attack of dizziness lasting two days. A year ago he had an operation for bleeding hemorrhoids. Micturition $\frac{D}{N} \frac{7-11}{0}$. Two weeks ago he had a bad sore throat. Nine years ago he weighed 171 pounds, his best weight. His usual weight was 170, his present weight 110.

Habits. Until five years ago he had been a moderate drinker. He formerly smoked two or three packages of cigarettes a day. At present he did not drink or smoke. He had taken six injections of morphia in as many months, with powders by mouth as prescribed for pain.

P. I. Three years ago he began to have attacks of dull aching pain in the back below the shoulders, particularly on the left, not severe enough to incapacitate him, improved by exercise. In a few weeks these passed away. Then while working he got wet through and began to have severe sharp pains in the stomach lasting two or three days with remissions of one or two days. He "could feel hard lumps there." After a month or two this type of pain ceased. The following winter he had pains in the left chest, generally constant, dull and aching, with exacerbations.

At the height of this he was laid up in bed and could find relief only by lying on the left side and taking morphia. He was in a hospital for three weeks. Knowing that his Wassermann was positive a year ago he took four injections of diarsenal and eighteen of mercury at the hospital. Since that time he had had fairly constant dull aching pain in the left chest, not radiating, except rarely to the shoulder blades, not affected by exercise, relieved by hot water bags. Since last summer he had had a number of attacks of dizziness lasting three or four minutes in which he fell to the ground without losing consciousness. For some hours after these he was dizzy.

P. E. He was spare, apparently in some pain. A few carious teeth. Pyorrhea. Chest barrel-shaped. *Lungs:* Slightly increased dullness with increased bronchovesicular breathing at both apices. *Heart:* Apex impulse not seen or felt. No enlargement to percussion. Sounds rapid, indefinitely heard in the left back. A₂ greater than P₂. Pulses normal. Artery walls palpable. Systolic. B. P. 140, diastolic 85. *Abdomen:* Tense, dull. Marked tenderness without spasm in the left upper quadrant. Liver dullness 6th space to 3 cm. below the costal border. Edge not felt. *Genitals* normal. *Shins* roughened. *Rectal examination:* Large boggy prostate. *Pupils* normal. Knee-jerks markedly increased. Other reflexes normal.

T. 99°, P. 109, R. 24. *Urine:* Amount not recorded. Cloudy. Sp. gr. 1030. *Blood:* Hgb. 80%. Leucocytes 11,000. Polynuclears 66%. Slight achromia.

During the physical examination and all night the patient complained of intense pain in the left chest. He could not sleep, but walked the floor most of the time. Early in the morning the pain was much worse. On being asked to cough he coughed up a teaspoonful of blood. He was much alarmed and continued coughing violently, raising another teaspoonful or two of blood. He fell back in the bed, and almost immediately died.

*Published in THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION with the permission of the Massachusetts General Hospital.—Ed.

DISCUSSION

By DR. RICHARD C. CABOT.

NOTES ON THE RECORD

Up to the beginning of the present illness I should say we have very little to guide us. There are suggestions in a great many directions, but nothing positive in any.

In considering the family history we should remember that heart disease of arteriosclerotic type is hereditary because arteriosclerosis is, and that tuberculosis is always a hereditary possibility.

Chancre treated by cautery may be syphilis and may not be syphilis; that is, what is treated often turns out not to be chancre. So this is only the possibility of that disease.

The dizziness, the hemorrhoids, the sore throats, and the loss of weight are all things that do not point in one direction rather than another. And though his habits are not good, we do not really get anything very definite there. So I should say we start the present illness pretty much at the base of things without knowing anything much about him.

The pain was "improved by exercise," so we are sure that it was not angina. What kind of pains in that part of the body are improved by exercise?

A PHYSICIAN: Gas pains.

DR. CABOT: Yes. There are pains in the back, in the region of the scapula, which are due to gas in the stomach and are relieved by exercise. Then there are the pains we used to call "rheumatism" and the nature of which we really do not know, pains accompanied by muscular tenderness and stiffness. We often hear people say, "In the morning I am stiff, but I limber up as the day goes on." We cannot state a definite pathology of these, but they are improved by exercise. I do not know anything else except those and gas pains which is improved by exercise.

Those "lumps" referred to might have been portions of the stomach or of the intestine distended behind a point of spasm, as in pyloric spasm, as the intestine is when there is intestinal cramp, colic or obstruction.

It seems to me that after ranging about a great deal in the different parts and systems

of the body we come down to the left chest. Any pain that has been fairly constant for six months in the left chest is likely to be due to local disease there, in the pleura or lung or heart. The striking thing about this is that it apparently has no relation to the heart because it is not increased by exercise, even though another symptom, the dizziness, suggests that it is connected with the circulatory system.

We know now that he had a positive Wassermann, so it is probable that the "chancre" was syphilis. The most important thing then is the probable history of syphilis and pain in the left chest. Next to that the attacks of dizziness, possibly arteriosclerosis, possibly circulatory trouble due to the syphilis.

That is a bad physical examination. I think if we go wrong, as we are quite likely to do, on this diagnosis we can blame this physical examination for a good deal of our trouble. In the first place the examination of the lungs means nothing. The examination of the heart tells only about the back, nothing about the front. I suppose that means that his circulatory system was all right.

"Knee-jerks markedly increased." That is a statement that should not be made in that form. We can say "knee-jerks lively." If increased there is almost always ankle clonus or Babinski. Otherwise the knee-jerks are not increased but merely lively. This is a very important distinction. Lively knee-jerks are very common; increased knee-jerks are very rare. We may examine thousands of patients and not see increased knee-jerks. I believe they were just lively here. So that so far as I get it that is a negative examination. That I do not believe because I see he died shortly after, and he had been in pain, in his left chest, for a year. I believe that if we had been there we should have found something. Sometimes however it is not human to examine a man the way we should like to because he is suffering too much.

The pain for which he walked the floor probably was not angina.

DIFFERENTIAL DIAGNOSIS.

That is a most unsatisfactory case. But let us put together what we have. We suppose he had syphilis. We do not know it, but he evidently thought he had it and was treated for it. We did not attempt to do a Wassermann here. There is no evidence except rough shins, which, if you have run your shins against as many obstacles as I have in the course of my life, does not seem very conclusive. Roughening of the shins in a cultivated lady who has never had any reason to bang them means quite a different thing from what it means in an ordinary man. So that we do not need to conclude anything about those shins, and aside from the statement about the Wassermann and treatment we have no evidence about syphilis. Nevertheless on the whole I think we had better suppose he had it.

The pain in the left chest is organic. A man does not have so long a pain as that from fatigue or nervousness. There should be a localized cause for that pain, and any such cause should have shown physical signs. Aneurism, cancer of the pleura, chronic pleurisy—those are the three things that naturally come to our minds. Aneurism can exist and cause pain without any physical signs except by X-ray, which we never had time to do here. Cancer of the pleura and pleurisy cannot. If the physical examination is correct those are both ruled out. If the physical examination is correct everything is ruled out except aneurism. Aneurism is suggested by the sudden death and the bleeding at the end. Aneurisms often leak that way by mouth before the patients die.

One could make quite a neat diagnosis there—syphilis in the beginning, producing aneurism, which ruptured into the respiratory passages and caused death. But I do not say it is so. If he had all that he might well have had something more discoverable even in the very short time he was here. Let us think what else he could have had.

Tuberculosis will cause blood-spitting. It will not cause such a sudden death as that, and if advanced enough to have brought him

to this condition it should have shown physical signs. I cannot make it tuberculosis.

There is no cardiac disease that I know of that would give that amount of pain without any relation to exercise. So that if we make a diagnosis of cardiac disease we have to suppose something else to account for the pain, and we have nothing else except aneurism. Furthermore, the cardiac examination is negative. Coronary artery disease can be wholly latent so far as the physical examination is concerned. It may give no irregularity of the pulse, no enlargement of the heart, no murmur. But it should give pain with relation to exercise, and this history does not. So even if it is coronary artery disease we have no reason to suppose so from anything before us.

I have made the only diagnosis I can make, and I do not feel any certainty of it.

A PHYSICIAN: Would that enlarged liver, three cm. below the costal margin, with the pain help you to think of syphilis and probably gastric crises?

DR. CABOT: In the first place we are not at all sure that the liver was enlarged. It comes down on percussion, but that may be due to a colon dilated with feces. If we do not feel the liver edge we do not pay any attention to the percussion dullness. His gastric pain apparently was of the past and not of the present. He had some tenderness under the left costal margin which we have not accounted for, I suppose due to the same cause as the pain in the chest, but he has had no gastric pain for a year. Gastric crises imply tabes, and tabes implies changes in knee-jerks and pupils which are normal here. So I think we can rule out gastric crises of tabes, and if he has syphilis in the abdomen or elsewhere I do not see that we can say so.

A PHYSICIAN: Any lesion of the bundle of His?

DR. CABOT: If there is anything wrong in the bundle of His we find it out by changes in the pulse leading us to confirm them by electro-cardiographic readings. They do not give pain. They do not give sudden death except where a man has had heart block with

very slow pulse such as he showed no evidence of. I do not believe there was any change in the bundle of His.

A PHYSICIAN: Coronary occlusion?

DR. CABOT: Sudden death always makes us think of that. My difficulty about this is to account for the last year of pain sufficient to cause him to take morphia but not related to exercise. That does not go with occlusion or with anything that I know except aneurism. Of course we are putting a lot of weight on a history that may be wrong. Perhaps the pain was worse on exertion. But if that were not so this would be the first case I ever heard of where coronary occlusion was the cause of steady pain without relation to exertion.

A PHYSICIAN: Pulmonary embolism?

DR. CABOT: That is a good suggestion in relation to any case of sudden death. The difficulty is that we do not like to make that diagnosis unless we know where the embolism came from. An embolism is a messenger sent from some base. When a man has had an operation, when a woman has been through pregnancy, when a person has had a broken compensation of heart disease and clots form in the heart, we are ready to suppose a pulmonary embolism. But I hate to do it when we have no previous evidence in the case as to where they may come from.

A PHYSICIAN: Gumma of the lung?

DR. CABOT: I never heard of pain from gumma of the lung. It can occur and can occur without our being able to find any physical signs, so it would not be strange that his chest should be as it is. But the only recognizable cases have caused very extensive signs as of a pleural effusion during life. I should not suppose we needed to consider that.

A PHYSICIAN: How about rupture of the heart?

DR. CABOT: That results usually from arteriosclerosis of the coronary arteries. If he had syphilis that is a perfectly good cause for such a thing. But we come back to the question I have already discussed about the coronary arteries. I have a sort of feeling

from the way he died that he had coronary artery disease. But the trouble is that we have all this mass of evidence between the syphilis and the termination which points the other way. But I should not be surprised if he had disease of the coronary arteries with either occlusion or rupture, even though the history is entirely against it.

CLINICAL DIAGNOSIS (FROM HOSPITAL RECORD).

Neurosyphilis.

DR. RICHARD C. CABOT'S DIAGNOSIS.

Syphilis.

Syphilitic aortitis.

Aneurism of the aorta with rupture.

Coronary sclerosis.

ANATOMICAL DIAGNOSIS.

1. Primary fatal lesion:

Syphilitic aortitis.

Aneurism of the aorta, with rupture into the left lung and left pleural cavity.

2. Secondary or terminal lesions:

Hemothorax, left.

Anemia.

DR. RICHARDSON: The head was examined and nothing abnormal found.

The heart and valves were negative.

The first portion of the aorta showed a slight amount of syphilitic aortitis, not extensive but producing at three places very small pouch-like dilatations. Above that the process faded out until we reached the junction of the arch and the descending thoracic. At that point was a large aneurism the wall of which had become adherent to the lung, had ruptured into the lung, and of course disrupted the ends of the bronchi from which the blood mentioned came. Then at the lower border it broke into the pleural cavity. From the pleural cavity we took out a blood clot weighing 1300 grams, the size of a liver.

DR. CABOT: How big was the aneurism? It is interesting to see how big it was, because it caused no physical signs.

DR. RICHARDSON: It was six inches by four.

DR. CABOT: Was it about in the median line or more to the left?

DR. RICHARDSON: It was on the left lateral aspect of the aorta, adherent to the left upper lobe.

The liver was negative.

The wall of the aneurism had eroded the vertebrae from the fourth to the seventh thoracic inclusive until they looked like spools with the discs sticking out. But it had not reached the spinal cord.

DR. CABOT: It must have pressed upon the nerves running about the chest and causing that pain. One of the extraordinary things about erosions of the vertebrae by aneurism is almost impossible to picture unless we have seen it. The vertebral pieces of bone are hard and the intervertebral discs are soft, yet the aneurism erodes the bones and leaves the discs sticking out, looking, as Dr. Richardson said, like spools, the broad part being the vertebral discs and the narrow part in the middle being the vertebrae. I wish that somebody who knows physics would tell me why it wears away the hard part and leaves the soft.

DR. RICHARDSON: I think Dr. Dwight used to say that the hollow viscera moulded the solid; but he never gave any reason why.

DR. CABOT: It seems as if there must be some chemical reason, that it could not be purely physics.

A SURGEON: It has been put on a mechanical basis by saying the thing that wears is the thing having motion, and the part that is worn is the motionless thing.

DR. CABOT: The discs are motionless.

I want to ask a general question about aneurism and its cause. Of course we have only had definite knowledge of the spirochetæ here for some ten years or so. But so far as you can remember at the present moment, have you ever seen an aneurism, excluding dissecting aneurism, that was due to arteriosclerosis without syphilis?

DR. RICHARDSON: We had one case here where there was an aneurism of the iliac.

DR. CABOT: I mean of the arch of the aorta.

DR. RICHARDSON: In a certain few cases where there has been an infection, an endo-

carditis, a short distance above on the aorta we may have an infection of the wall with aneurism.

DR. CABOT: Streptococcus?

DR. RICHARDSON: Yes, and that resulting in an aneurism at that point. Other than that, no.

DR. CABOT: I have seen that, but that is not arteriosclerosis. In honor of Sir William Osler's seventieth birthday last July a group of his friends wrote two memorial volumes which have just been published and which contain a great deal that is very interesting. Dr. L. F. Barker writes on arteriosclerosis, and makes the statement that it causes aneurism of the arch of the aorta. I have been watching for that for over ten years here and I have never seen it. I want to follow up Dr. Barker and see whether he did really get any post-mortem evidence. I have often said to students, "A person who has arteriosclerosis of the aorta, which is enormously common, is in no danger of aneurism."

DR. RICHARDSON: Except in dissecting aneurisms. Sometimes they break.

DR. CABOT: They are exceedingly rare.

DR. RICHARDSON: It is a pretty small percentage. We had one remarkable case, a so-called double aorta, where a dissecting aneurism formed a double tube and the lower end of the aneurism joined and communicated with the right common iliac artery.

How about the head in this case? If he had a syphilitic lesion in the head, he might have had a vessel break. It would account for his sudden death.

DR. CABOT: But what you found was a better explanation.

A PHYSICIAN: If a man had this case in private practice would it be a medical examiner's case?

DR. RICHARDSON: It would depend on the medical examiner. If you are asking me what I would do if you told me that you had a case of that sort that you had been treating—

A PHYSICIAN: I mean seeing it once.

DR. RICHARDSON: Then of course you have not been treating it, and that would

settle it at once. You might perhaps tell me that you had been treating him and you knew more about the man than anybody else in the world. Then I should say you could sign the certificate. A doctor has to take some responsibility. There is no use of raising an office to the *n*th power simply because you happen to be in that office. The sane thing to do when in doubt is to call up the medical examiner.

AN ALL-AMERICAN HEALTH CONFERENCE.

The first of a series of regional health conferences authorized by the International Health Conference in Cannes is to be held in Washington, D. C., December 6-13. It "will be devoted to a consideration of venereal diseases, which, according to conservative estimates, constitute one of the world's most terrible plagues."

The conference is being organized under the joint auspices of the U. S. Interdepartmental Social Hygiene Board, the U. S. Public Health Service, the American Red Cross and the American Social Hygiene Association. Prof. William H. Welch, of Johns Hopkins, has consented to serve as president, and already assurances have been received that some of the foremost physicians and sociologists will participate. Prominent health officers and sociologists from all parts of North and South America will attend.

The conference will review past experiences and existing knowledge as to the causes, treatment and prevention of venereal diseases, and will formulate recommendations relating to a practicable three-year program for each of the North and South American countries participating. In addition it will make suggestions for putting such programs into effect.

In speaking of the proposed conference, Surgeon General Hugh S. Cumming, of the U. S. Public Health Service, said: "The United States is in the front rank of the countries which have organized against the Great Red Plague, and a consideration of the various measures which have proved of value in different communities will undoubtedly contribute much to further progress in the countries represented at the conference. More than any other important communicable disease, the spread of the Great Red Plague is inextricably bound up in a mass of social, economic, educational and recreational problems. The success thus far attending the campaign against the venereal disease is due largely to the fact that this interrelation has been recognized and that the campaign has enlisted the cooperation not only of physicians and sanitarians, but of sociologists, judges, probation officers, educators, the clergy and good citizens generally."

PUBLISHER'S NOTES

TREATMENT OF THE PAROXYSM OF ASTHMA.

The attention of our readers is invited to the brief article on "Adrenalin in Medicine," which will be found in the advertising section of the current number of this journal. While, obviously, this space is purchased for advertising purposes by Messrs. Parke, Davis & Company, it has been put to a novel use by the publication therein of a scientific essay of

unusual merit in which a vexatious problem is discussed.

Whatever intelligence the future has in store on the pathology of asthma, the present state of our knowledge justifies the use of any dependable therapeutic measure for the relief of the acute paroxysm. Morphine is objectionable for reasons that are generally accepted. Per contra, Adrenalin does not narcotize the patient. It affords him almost instant relief, with no disagreeable sequelae.

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*Cited by Gradwohl and Blairas, The Newer Methods
of Blood and Urine Chemistry, The C. V. Mosby Co.,
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ORIGINAL ARTICLES

DIAGNOSIS OF ECTOPIC GESTATION.*

THOMAS TRUELSEN, M. D.,
Tampa, Fla.

Analyses by various authors tend to show that the diagnosis of ectopic gestation is not made before rupture in the vast majority of cases. On the other hand one author, Polak, states that a positive diagnosis of unruptured ectopic gestation should be made in the vast majority of cases and that in his clinic and private practice this diagnosis was made in 85 per cent of the cases. This high percentage he believes was attributable to the fact that a careful history was taken and a thorough physical examination made in every case.

In order then to improve our diagnostic acumen it will be advantageous to study the history and the physical findings.

Significant Data in History.

In eliciting the history of previous pelvic trouble very little will be found that can with certainty be brought into a causative relation. About two-thirds of the cases will give a negative history of any previous pelvic trouble. And if we accept Webster's view that ectopic gestation can take place only in a site that gives the decidual reaction, we must come to the conclusion, as he does, that mechanical forces or factors in the pelvis as a cause are largely speculative and incidental. They are not helpful in establishing a diagnosis.

Other factors noted in careful history taking that are not of much diagnostic help are the age of the patient, the time of occurrence from date of marriage, the time of occurrence from date of last pregnancy, and the

previous menstrual history. The average age of patients is about thirty years. Graham reports a case in a girl of fifteen. Ostler reports a case at one and a half months and one at eighteen years after marriage. In about half of his cases the previous menstrual history was normal.

Presumptive symptoms of pregnancy are sometimes noted in a careful history. Their diagnostic value and help in ectopic gestation are the same as in normal pregnancy, certainly not greater.

Two factors of the utmost importance in our consideration are pain and menstrual disturbance.

Pain.

Pain is a most constant symptom in ectopic gestation. Its character varies. Usually it is mild or only moderately severe in its beginning. It is such as we may often find in many pelvic and other abdominal disturbances. If we bear in mind that the pain in the beginning is due to distention by bleeding into the tube or amniotic sac, we can understand that it is usually clear-cut and sharp, and that its duration is often short; that it is cramp-like, intermittent, and recurrent with perhaps intervals of complete relief. Its incidence and greatest intensity is indicated by the patient as being in one side of the pelvis, and its recurrence as being always on the same side. Even in tubal abortion the pain may not be severe, depending as it does on the amount of hemorrhage and the degree of propulsive pressure to extrude the embryo. Rupture of an ectopic gestation usually intensifies the pains; and whereas before rupture the patient usually locates her pain rather definitely, now it may be described as a general pelvic pain, or a general abdominal pain, or even as an epigastric pain. It is now no longer the sub-acute pain of the former definite, cir-

*Read before the forty-seventh annual meeting of The Florida Medical Association, at Daytona, May 12-13, 1920.

cumscribed lesion, but rather the pain of the acute abdomen, often with its concomitant symptoms of shock. It is well to bear in mind that the pain in these severe cases is not as distinctive nor as helpful in making a diagnosis as in the earlier, milder cases. The pains so far described are the pains caused by stretched tissues and the pains caused by the sudden freeing of blood into the abdominal cavity. Other pains frequently complained of by the patient are associated with the acts of micturition and defecation, especially with the latter. The bladder disturbance is more often described as an irritability rather than as a pain, but the associated disturbance with the act of defecation, although it too may be merely an irritability, is often a pain, stabbing, cramp-like and sickening in its character. This little group of symptoms, by itself not very significant, gains in importance when we bring out in the history the absence of a preceding or concomitant inflammatory pelvic condition. Then, too, the directive influence of this little group of symptoms may lead to a diagnosis of an intestinal disturbance when not considered with due circumspection. So altogether it is a little group well worth remembering.

Menstrual Disturbance.

The menstrual disturbance is the second most constant symptom in ectopic gestation. Usually there is a cessation of menstruation for a period or two. Upon the death of the embryo the uterine decidua loosens and may come away intact, but more often it comes away in spreads. This gives rise to the external hemorrhages. Not always is the menstrual period skipped entirely; sometimes it is merely delayed for several days or a week. In exceptional cases the menstruation occurs at the normal time. The menstrual flow is characteristic. It is neither large nor free. It may be continuous, but oftener it is intermittently prolonged, sometimes for weeks. It is dark, tarry, sticky, and contains shreds.

Before taking up the physical signs it will be well to direct our attention to several other findings well to bear in mind, not so much because they are directly helpful in

making a diagnosis, but because their misinterpretation may add perplexity, or even wean one away from the correct diagnosis. I wish to call your attention to the temperature, blood-count, and chills and fever.

Temperature.

Ectopic gestation is not a condition of normal temperature. Some elevation of temperature is present in almost every case during some part of the twenty-four hours. It will range between $99\frac{1}{2}$ and $100\frac{1}{2}$ and even higher. Do not be misled by this temperature to diagnose an inflammatory condition.

Blood-Count.

The blood-count will show a leucocytosis in the majority of cases. The count may run rather high. Cases are reported running as high as 36,000. Counts of 10,000 to 20,000 are quite common. In these cases of leucocytosis, the polynuclear cells are usually increased, even up to 90 per cent. In cases with a rise of temperature of any moment, the leucocytosis and polynuclear cells often seem to increase in greater proportion. The red cells and the hemoglobin, of course, are decreased in proportion to the amount of blood lost. It will be readily seen that a blood picture with a decided leucocytosis and increased polynuclears, accompanying a rather acute pelvic condition with temperature, may be the cause of some perplexity, and may embarrass the correct diagnosis.

Chills and Fever.

About 20 per cent of the cases complain of chills and fever. Upon inquiry it will be found that they usually come on simultaneously with pain. When they are delayed their interpretation may be confusing. Infection is not their cause, and this must be borne in mind. They are caused by a sudden freeing of foreign material into the peritoneal cavity. The same complaint is often made in ruptured appendix or gall-bladder or perforated gastric ulcer. They are an accompaniment of any severe pain or shock.

Physical Examination.

A thorough physical examination, abdominal and pelvic, is very important, not so

much to establish the diagnosis, but to secure it. On palpation in the early cases one gets tenderness on pressure in one or the other lower quadrant, probably also some rigidity, and in the more advanced cases also some general distention. If a mass can be made out it will feel boggy and elastic. It will be very tender and ill-defined. While making a vaginal examination one notes the discharge, dark, tarry, sticky, containing shreds perhaps. The vaginal examination is painful and the moment the finger attempts to lift the cervix, severe pain may be experienced. This tenderness and pain are important and characteristic findings. A few days after the rupture has taken place, the vaginal examination will be less painful. The cervix will be softened, the os patulous, and the uterus somewhat enlarged, and its position forward unless bound down by some previous inflammatory condition. According to the degree of advancement of the pregnancy and the amount of hemorrhage one will feel a mass, either small or large and very tender. The tenderness usually interferes with one's efforts to outline the mass exactly and one is left with the impression that it is ill-defined, the same impression one got while palpating the abdomen.

TREATMENT OF SYPHILIS OF THE CENTRAL NERVOUS SYSTEM.*

RALPH N. GREENE, M. D.,
Jacksonville, Fla.

In the beginning, allow me to state that there are no elements of mystery about syphilis of the central nervous system and that many of the mixed conditions which present differential neurological diagnostic problems are rendered more simple and more responsive to satisfactory results in treatment when the underlying cause, viz., syphilis, is discovered.

There are three broad classifications of neurosyphilitic manifestations. In the first

class we find those conditions due to meningeal irritation manifesting themselves by headaches and causing cytological changes in the spinal fluid. In this class may be considered cases of acute paralyses, optic atrophy and bladder disturbances.

In the second broad classification we find cases of meningo-encephalitis in which the differentiation between tabes and paresis is sometimes difficult. Indeed, it may be said that some of the cerebral manifestations of syphilis cannot be differentiated from paresis, except at post-mortem examination. A therapeutic differentiation is often possible in cases where treatment has been properly applied.

The third grouping we have to deal with is paresis and tabes wherein there is neuronal degeneration. In this type it is generally agreed that treatment is directed not with the hope of repairing destruction of nerve tissue which has already occurred, but with the hope of bringing about an arrest of the process.

Before attempting to discuss treatment, attention is invited to the numerous studies of the characteristics of the different strains of spirochetes. It has been shown, fairly conclusively, that the spirochetes in cases of paresis are of less virulence than in cases of acute and widespread syphilitic invasion of the central nervous system.

Rabbits inoculated with spirochetes from the brains of paretics do not develop lesions as quickly as do rabbits who are injected with spirochetes from acute constitutional syphilis.

It is further interesting to note that invasion of the brain and cord membranes may occur very early after the initial lesion, but in paresis and tabes the invasion of brain and cord tissues is usually postponed for at least two years from date of first infection.

Much has been said about the use of salvarsan and salvarsanized blood serum in the treatment of central nervous system syphilis. In my own experience, I am convinced that all cases of syphilis of the central nervous system are not to be treated in a routine manner.

*Read before the forty-seventh annual meeting of The Florida Medical Association, at Daytona, May 12-13, 1920.

In the first grouping where symptoms are acute, life at stake, and the meninges only involved, I believe that we are justified in adopting intensive treatment by the administration of two- or three-tenths grams of salvarsan daily, repeating until the patient shall have received the limit of salvarsan saturation, at which time, during an interval of a few days, some of the mercury preparations may be administered, either hypodermatically or by inunction.

Unless untoward symptoms develop, this treatment, in my opinion, should be continued with interruptions made necessary by skin or renal symptoms for a period of eight weeks, following which the treatment should be along the lines which I have mapped out for the conduct of cases in class two, viz., cerebral manifestations.

In this group, viz., cerebral manifestations, the danger of loss of life is not so great, nor the symptoms so grave, and it is therefore probable that this class may be treated with less enthusiasm than should be exhibited in the first, or meningeal, type of syphilis. Inasmuch as there is often a meningo-encephalitis, it is probably proper to administer initial treatment as above outlined for a period of eight weeks, following which larger doses of salvarsan, given at semi-monthly intervals, should be carried out for a long period of time. In these cases the subjects are impressionable and unduly optimistic and inclined to magnify results. If they have paresthesias or the beginning of ataxias, we should practice suggestion and by mechanical training reeducate the coordination of movement where interfered with.

In the third general type, viz., paresis or tabes, I must admit that my experience has not lead me to the belief that a great deal of good can be accomplished. We must not lose sight of the fact, however, that cases of paresis that do not receive active anti-syphilitic treatment, but who are given treatment with a view of accomplishing general constitutional improvement, often show distinct remissions. These remissions occurring

without distinguishable cause, are the means of causing investigators to adopt a position of unwarranted optimism when applying some new form of therapeutics.

Much has been said in the past about the efficacy of introducing salvarsan or salvarsanized blood serum into the spinal canal. When we consider that experiments conducted in the United States Public Health Service Hygienic Laboratory and elsewhere have proved conclusively that after intravenous injections of salvarsan more salvarsan can be recovered within twenty-four hours from the spinal fluid than it is safe to inject directly into the spinal canal, we are confronted with the necessity for seriously considering the advisability of subjecting a patient to intraspinal treatment for the purpose of introducing into the spinal fluid a lesser quantity of salvarsan than can be gotten into the spinal fluid by intravenous administration of 606.

It seems to me that the demonstration of salvarsan into the spinal fluid, following intravenous injection, is conclusive proof of the permeability of the choroid plexus and that the only advantage of introducing an autosalvarsanized blood serum is based upon an unproven hypothesis of this serum containing some specific antitoxic properties.

I am convinced that routine spinal puncture with withdrawal of the spinal fluid rids the patient of a toxic fluid containing debris in the form of degenerated nerve cells and other cellular matter. The drainage of spinal fluid apparently increases a secretory function of the choroid plexus.

Frequent drainage of the spinal fluid and injection of salvarsanized blood serum or even salt solution may have the effect of producing a localized leucocytosis with attending beneficial effects around the roots of the spinal nerve trunks.

In general I may summarize my remarks relative to treatment of syphilis of the central nervous system by making a plea for more intensive and more prolonged treatment with frequent examinations of the spinal fluid and the continuance of treatment

so long as significant biologic changes are found in the spinal fluid.

I do not believe that better results can be obtained from intraspinal treatment than by the old routine intravenous administration of salvarsan. I advocate frequent spinal punctures.

It has been proposed to treat cases of paresis by puncture of the lateral ventricles of the brain, and I only mention this treatment for the purpose of condemning it.

A DISCUSSION OF SOME DIFFERENT TYPES OF DIARRHEA.

GEORGE M. NILES, Ph.G., M. D.,
Atlanta, Ga.

Clinically, diarrhea may be defined as abnormal rapidity of intestinal peristalsis, accompanied by frequent evacuation of the bowel contents, which are too liquid or watery in character.

The term "loose bowels" is a comparative one, for some there are whose bowels normally move two or three times daily, while others of a constipated habit would be in a diarrheal condition were the intestines to be evacuated twice in twenty-four hours.

Diarrheal stools are caused by the excess of water in the feces, and may be due to the liquid contents of the small intestine being so rapidly hurried into the colon that little absorption can take place in the small intestine. The free transudation of water from the blood-vessels or glands may also be a factor. At times increased peristalsis is the only cause, and both the large and small intestine may be involved, while no organic lesions are present. There are numerous ways by which increased intestinal peristalsis may be originated. In the majority of instances it is the result of anatomic changes caused by disease, as intestinal catarrh, ulcers from typhoid, etc. Again it may be caused by irritability of nerves of the intestinal walls, or it may be due to a central lesion of the nervous system. In considering a diarrhea it is important to know whether it is produced by abnormal exudation with increased per-

istalsis of the large intestine; or whether the peristalsis of the small intestine is increased, as in the latter unchanged digestive fluids and large amounts of undigested foodstuffs may be hurried through the small gut resulting in great damage to the nutrition.

The type of diarrhea brought about by intestinal ulceration is discussed elsewhere. This form is secondary to the anatomic changes and should be looked upon as an incident, wherein, if the real cause is controlled or cured, the diarrhea quickly ceases.

The type of diarrhea which will now be covered is that due to irritation from substances contained in the bowel contents, in which no intestinal lesions are originally present.

This type may be classified as follows:

Irritative diarrhea from bowel contents, as diarrhea dyspeptica from the presence of undigested food; diarrhea gastrica (gastrogenic diarrhea) in which the stomach permits undigested food to escape into the small intestines; diarrhea stercoralis, or that produced by irritating fecal matter; diarrhea entozoa, or that produced by intestinal parasites; diarrhea from irritants transmitted in the blood, as uremia; and nervous diarrhea.

Diarrhea Cathartica.—This term, as used by Nothnagel, is intended to mean undue bowel movements brought about by the ingestion of strong cathartic medicines. In many instances a catarrhal condition of the intestinal mucosa may be set up by the unwise or prolonged use of cathartics, and a severe diarrhea may ensue.

Diarrhea Dyspeptica.—This is probably the most common, and is produced by irritating or indigestible food, as fresh or unripe fruit, cucumbers, pickles, etc. There is great variation as to susceptibility, for certain articles that may set up a violent diarrhea in some individuals may either cause no disturbance, or even constipate others; while some individuals can eat with impunity certain articles under favorable circumstances, while under other circumstances the same articles will set up a diarrhea.

The food may contain pathogenic organisms when ingested, or may ferment and spoil after entering the intestines. These are the conditions under which are observed the various food poisonings, and in which important considerations, legal and otherwise, may be involved.

Diarrhea dyspeptica, uncontrolled, may merge into the chronic catarrhal form.

Diarrhea Gastrica, or Gastrogenic Diarrhea.—A number of years ago Einhorn called attention to cases of diarrhea, in which the stomach was entirely at fault. In the majority of instances there was a marked diminution or entire absence of hydrochloric acid in the stomach, and with a patulous pyloric outlet, the food was thrown into the small intestine in an unprepared condition.

In such cases there are flatulence, borborygmus, and colicky pains, with a tendency to bowel movements soon after meals. This condition, too, may develop intestinal catarrh.

Diarrhea Stercoralis.—This is an intermittent diarrhea noted in constipated persons, in which after a period of constipation, there sets in a short but painful diarrhea, accompanied by cramps, great flatulence, and the passage of hardened lumps of feces. After the bowels are thoroughly emptied, relief is obtained.

Diarrhea Entozoica.—This is the form brought on by intestinal parasites, as the tapeworm or others. Like other forms of diarrhea, there are at first no organic lesions present, but these may appear after long-continued irritation.

A very marked and sometimes intractable diarrhea may be produced by irritants in the blood, as the diarrhea of septicemia, nephritis, diabetes, cholera, etc.

In this class may be properly included the "compensatory diarrheas," being that form of diarrhea in which the toxic products of catabolism are simply washed out, with neither material harm to the bowel nor systemic shock.

Types of compensatory diarrhea may be classified as (1) diarrhea concomitant with deficient or perverse catabolic processes; (2)

diarrhea which is the consequence of functional or structural disease of certain excretory organs; (3) diarrhea occurring during the period of systemic physiological decline. As illustrative of the first type may be mentioned the diarrheas of gout, Addison's disease, diabetes, goiter, and pellagra. The second form of compensatory diarrhea may present itself as a concomitant of impaired renal function, or as the result of extensive burns over the abdomen.

That certain diarrheas, not exhausting, but rather grateful in their effects, are not infrequent in old people, will be noted by all careful observers, and I have under treatment at present a hale old gentleman who welcomes his fortnightly diarrhea as a salutary visitation. In these forms of compensatory diarrhea the discharges from the bowel consist in the main of incompletely or perversely catabolized substances, or catabolic products normally excreted by other emunctories.

This type may also represent certain toxic states of the blood with secondary elimination of toxins through the intestinal mucous membrane. We should not forget, however, that it is possible for an irritative diarrhea to occur simultaneous with one of a compensatory nature, or that secondary inflammatory lesions of the intestinal mucosa may merge this beneficial drainage into an exhausting process; and it can be readily understood how the passage of these toxins from the blood, plus other excrementitious substances, may intensify the diarrhea, and transform the disturbance into one of a non-compensatory character.

Further studies, since the compensatory character of pellagrous diarrhea was advanced by the writer eight years ago, have tended to prove the truth of that contention. The early diarrhea in this disease is of central origin, though the later manifestations may, and generally do, become irritative. Another probable cause of the diarrhea lies in the great diminution of tegumentary excretory power entailed by the dry and scaly skin, which would demand a vicarious activ-

ity of both the bowels and kidneys. The resident physician of one of the local sanatoria has reported to me a recent case of pellagra coming under his observation, where the patient seemed to be progressing favorably, but on checking suddenly his rather profuse diarrhea, he went into coma, dying in about twenty-four hours.

It has been observed that within two days after a burn, not necessarily deep, but covering an extensive area, a very watery diarrhea often occurs, followed by an improvement in the shock and clearing up of the mental hebetude or coma. This is evidently a vicarious elimination of autotoxicoes, and it is probable that, in addition to the curtailed activity of the skin, there are also some poisonous gases generated in the body, which are discharged through the bowels along with other catabolic products. The colliquative diarrhea supervening after a long confinement from a burn, resulting from both systemic exhaustion and ulcerated intestines, is generally a terminal symptom and not at all compensatory.

In uremic intoxication we probably note the most frequent compensatory diarrhea, though this symptom is hardly as common as the vomiting. As far back as 1859 Treitz claimed that the intestinal irritation occurring in the course of nephritis was produced by ammonium carbonate formed in the intestinal tract by the urea excreted into it. This irritation may progress until catarrhal enteritis, and, later on, uremic ulcers are formed, provoking continuous intestinal disturbances not compensatory in their nature. The diarrhea in uremic conditions, therefore, where there are no decided changes in the intestines, may generally be regarded as compensatory, and treated as such.

In old people, especially women past the climacteric, we notice occasional attacks of diarrhea, apparently unprovoked by dietary indiscretions or atmospheric changes, brief, painless, and followed by no exhaustion. This periodical washing out of catabolic products is probably due to the fact that the tegumentary eliminative functions in the old of both

sexes are incomplete, while in some women the body continues to require that occasional readjustment formerly afforded by the menstrual flow.

Diarrhea Nervosa (Nervous Diarrhea).—This depends on nervous or psychic disturbances, without any morbid changes in the walls of the intestines. It is entirely compatible with this type for a marked diarrheal discharge to be present, while no impairment of the digestion is felt by the patient.

True nervous diarrhea may originate from excessive stimulation of the nerves governing peristalsis, or from the transudation of great quantities of serous material into the bowel brought on by nervous influences. In many cases both conditions obtain. In some instances the stimulus may originate in the nerve-centers, and, being transmitted through the fibers of the vagus, sympathetic, or splanchnic nerves, may thus reach the intestinal ganglia.

Examples of nervous or psychic diarrhea are easy to find, and can be traced directly to some emotion, as fright, shock, or disgust, which send their impulse to the brain centers and from thence reach the intestines.

Nothnagel reports instances of chronic nervous diarrhea in persons who are attacked with gurgling, abdominal pain, tenesmus, and loose evacuations as soon as they find they can secure no access to a convenient toilet; while in others the sight of a toilet produces this symptom. Some patients may have attacks at definite hours, without any relation to surrounding conditions.

With some people a regular syndrome of symptoms may precede the diarrhea, as vertigo, giddiness, congestion of the head, reddening of the face, hot flushes over the body, fear, oppression, palpitation, and rapid breathing; and, strange to say, these distressing manifestations quickly disappear after several copious diarrheal movements of the bowels.

In a diarrheal attack the number of stools may vary from two to even fifteen, and consist of liquid with little if any mucus. Generally the first movement is compara-

tively normal, the next mushy, and the rest watery. This form of diarrhea is found in hysteria, neurasthenia and psychasthenia, and even in healthy people after a nervous shock. The instance of soldiers suffering from nervous diarrhea when they first "face gunpowder" is known.

Charcot describes attacks with tabes (intestinal crises) much in character like the gastric crises; and Peyer mentions a reflex form of nervous diarrhea concomitant with abnormal conditions of the genitourinary tract, as from uterine catarrh, nocturnal emissions, spermatorrhea, and sexual excesses. Fischel reports a stubborn case of diarrhea, resisting all treatment, cured by replacing a reflexed uterus.

To differentiate and orient these various types will generally enable the medical attendant to decide on the proper therapeutics; and it is hoped that this somewhat brief discussion will be found of both interest and profit to the reader.

922 Candler Building.

PROPAGANDA FOR REFORM.

PREVENTION OF GOITER.—The latest report on the prevention of goiter by administration of sodium iodid by Marine and Kimball—an investigation carried out under a grant from the Therapeutic Research Committee of the Council on Pharmacy and Chemistry—indicates a striking difference between those girls not taking and those taking iodine. The difference is manifested both in the prevention of enlargement and in a decrease in the size of existing enlargements. Of 2,190 pupils taking 2 gm. of sodium iodid twice yearly, five have shown enlargement of the thyroid, while of 2,305 pupils not taking the prophylactic, 495 have shown enlargement of the thyroid. Of 1,182 pupils with thyroid enlargement at the first examination who took the prophylactic, 773 thyroids decreased in size, while of 1,048 pupils with thyroid enlarged at the first examination who did not take the prophylactic, 145 thyroids decreased in size. (*Jour. A. M. A.*, September 4, 1920, p. 674.)

SOME MISBRANDED VENEREAL NOSTRUMS.—The following preparations have been the subject of prosecution by the Federal authorities under the Food and Drugs Act on the ground that the therapeutic claims were made for them were false and fraudulent: Injection Cadet (E. Fougere and Co., New York), a dilute watery solution of copper sulphate and unidentified plant material. Knoxit Injection (Beggs Manufacturing Co., Chicago), a solution of zinc acetate with alkaloids of hydrastis, in glycerin and water. Knoxit Liquid, a solution of zinc acetate with alkaloids of hydrastis, in glycerin and water. Knoxit Globules, essentially a mixture of volatile and fixed oils and oleoresins, including copaiba balsam, cinnamon and cassia. Grimault's Injection (E. Fougere and Co., New York), a weak watery solution of copper sulphate and plant extractives, probably matico. Halz Injection (Edw. Price Chemical Co., Kansas City, Mo.), consisting essentially of zinc sulphate, boric acid, glycerin, traces of alum and formaldehyd and water. Tablets which seem to go with the product consisted essentially of calcium and magnesium carbonates, copaiba, a laxative plant drug, plant extractives, a small amount of an unidentified alkaloid, sugar and starch. Noxit (Frederick F. Ingram Co., Detroit), consisting essentially of opium, berberine, a zinc salt, glycerin, alcohol and water. Crossmann Mixture (Wright's Indian Vegetable Pill Co., New York City), essentially an alcoholic solution of volatile oils, including balsam copaiba and cubebs. Santal-Pearls (S. Pfeiffer Mfg. Co., St. Louis, Mo.), consisting essentially of a cinnamon-flavored mixture of santal oil and copaiba. Cu-Co-Ba-Tarrant (Tarrant Co., New York City), consisting essentially of a mixture of extract of cubebs and copaiba with magnesium oxid. Hygienic and Preservative Brou's Injection (E. Fougere and Co.), consisting essentially of acetates and sulphates of zinc and lead, morphin, water and a very small amount of alcohol. (*Jour. A. M. A.*, September 25, 1920, p. 891.)

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THE PHYSICIAN'S RESPONSIBILITY: AN IMPORTANT DECISION ON PROFESSIONAL SECRECY.

The recent decision of the Supreme Court of Nebraska, abstracted in the *Medicolegal* department of *The Journal* last week,¹ is of importance and interest to practicing physicians, and especially to health officers. It establishes for the first time, by the decision of a court of last resort, the exact relation that exists between a physician and his patients, on the one hand, and a physician and the public, on the other. The details of the case, as shown by the evidence, are interesting and unusual. The plaintiff, while stopping at a small hotel, consulted a local physician, the defendant, regarding some sores that had appeared on his body. After an examination, the physician told the plaintiff—his patient—that he believed the disease to be syphilis, but that it was impossible to make a positive diagnosis without a Wassermann test, for which he had no equipment. The defendant physician was also the physician of the hotel, and the family medical adviser of the owner. He told the plaintiff that there was danger of communicating the disease to others in the hotel and asked him to leave the hotel the next day, which the plaintiff promised to do. On the following day, the physician, while making a professional call on the manager of the hotel, who was ill, learned that the plaintiff was still there. He thereupon warned the manager's wife that he thought the plaintiff was afflicted with a contagious disease, and advised her to use special precautions to avoid infection. As a result of this warning, the plaintiff was forced to leave the hotel. He consulted a physician in another town, who, after a negative Wassermann test had been made, was unable to say whether the plaintiff had syphilis or not. The plaintiff, thereupon, brought suit against the physician, claiming damages on the ground that he had been injured by a disclosure of a confidential communication, which disclosure constituted a

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breach of professional confidence on the part of the physician. There was no dispute regarding the facts; the question before the Supreme Court was whether the statement of the defendant physician that the plaintiff was suffering from a contagious disease constituted proper grounds for damages.

The court pointed out that, under the common law, no privilege exists between physicians and patients, and that this ruling prevails except when changed by statute. This means, in everyday language, that, contrary to the opinion generally held by both physicians and the public, communications made to physicians are not under the obligation of secrecy but have the same legal status as communications made to any one else, unless the state legislature has passed a special law on this subject. In Nebraska there is no special law making communications to physicians privileged. The legislature in 1913 passed a law providing that a physician should not be allowed to disclose on the witness stand any confidential communication made to him in his professional capacity. The object of this statute is obvious. It is to prevent confidential communications being used as evidence against the person making them or, in other words, to protect an individual from being forced to testify against himself. But in the present case the physician was not on the witness stand, so that this statute did not apply. Another statute—the medical practice act—in defining unprofessional and dishonorable conduct for which a physician's license may be revoked, includes among the acts of such conduct "betrayal of a professional secret to the detriment of a patient." Is such a communication as the defendant made in this case "unprofessional and dishonorable conduct"? After an exhaustive discussion, the court decides that it is not.

This is the first time that such a question has come before any American court of final appeal; hence the language of the court is important and worthy of repetition. The court says that information given to a physi-

cian by his patient, though confidential, is subject to the understanding that if the patient's disease is found to be of so highly contagious or infectious a nature that it may be transmitted to others unless the dangers of transmission are disclosed, then the physician is warranted in making so much of a disclosure to such persons as is reasonable and necessary to prevent the spread of the disease. Putting this ruling in ordinary language, it means that the court recognizes the fact that while a physician owes a duty to a patient to respect his privacy, he owes a duty to the public to protect it against infectious disease, and that of these two duties the duty to the public is the greater. Yet the court recognizes that this duty to the public must be properly safeguarded. It furthermore says that when a physician makes a disclosure, he must be sure that it is necessary to prevent the spread of the disease, and must act in good faith with reasonable grounds for his disclosures and without personal malice toward the infected person. Having observed these precautions, he cannot be held liable, even though he is mistaken in his diagnosis and has stated that his patient is afflicted with a disease that he does not have. In other words, the question at issue is not the accuracy of the physician's diagnosis. The law does not require the physician to be infallible; he is only required to possess the average skill and ability of other physicians in similar circumstances and to exercise due care and skill. After having made a diagnosis to the best of his ability, if he believes honestly and without malice that the patient is a danger to another individual or to the community, he is justified in communicating so much of his belief as may be necessary to protect others from contracting the disease. The decision recognizes the fact that while a physician owes a duty to his patient, he also owes a duty to his other patients and to the public.—*Jour. A. M. A.*

1. Disclosure of Confidential Information as to Contagious Disease. *J. A. M. A.* 75:1153 (Oct. 23) 1920.

CASE RECORDS.*

(ANTE-MORTEM AND POST-MORTEM) AS USED IN WEEKLY
CLINICO-PATHOLOGICAL EXERCISES AT THE
MASSACHUSETTS GENERAL HOSPITAL
EDITED FOR THE USE OF PRACTITIONERS BY

RICHARD C. CABOT, M. D., AND
HUGH CABOT, M. D.

F. M. PAINTER, ASSISTANT EDITOR

CASE 6103

An unoccupied Swede of sixty-five entered September 30.

F. H. Unimportant so far as known.

P. H. He had always been well.

P. I. For two years he had had difficulty in micturition, increasing frequency, and urination at night. A month before admission he saw a doctor, whose medicine was followed by temporary improvement. Two weeks ago he went to another doctor whose advertisement he had seen, and who passed instruments several times through his urethra, causing great pain and much subsequent bleeding. September 27th this doctor passed larger instruments. On the train going home the patient had chills and bled from the urethra. September 28th he was very ill, unconscious. His genitals were much swollen. A physician at his home gave medicine for heart trouble and local hot applications. September 29th the swelling was much increased. For the first time since September 27th he passed a very small amount of urine.

P. E. He was a poorly developed and nourished old man with sallow and wrinkled skin. The mucosæ were pale. The *lungs* were hyperresonant in front. The back was not examined. The apex impulse of the *heart* was in the 5th space, nipple line. There was a soft systolic murmur at the apex. *A²* was accentuated. The *abdomen* and *extremities* were not remarkable. *Genitals*: There was tremendous edema of the penis. The scrotum was purplish red and swollen to several times its normal size. The discoloration extended to and beyond the rectum. The *pupils* were normal, the *knee-jerks* sluggish.

T., P., R., urine and *blood* before operation not recorded.

Operation was done the day of entrance. The patient was in poor condition after it, with irregular pulse and heavily coated tongue. He was given 1200 c. c. of saline subpectorally. Next day he seemed better, but was semistuporous and slept a good deal. Much slough was trimmed off the wound. The dressings had a very foul odor. There was good drainage. He continued to take fluids freely. Locally the wound grew better. He became weaker, however, and comatose. The temperature was 97.5°-99.6°, the pulse 88-111, the respirations 21-26 until October 5th, when the pulse rose to 123. October 6th they were respectively 100.3°, 132, and 42. That day the patient died.

DISCUSSION

BY DR. HUGH CABOT

I think we must assume some lesion of the urinary tract. It is by no means certain that he had a stricture, but this picture is far more commonly associated with stricture than anything else. The old picture which masqueraded in text books and to a certain extent still masquerades, of rupture of the urethra behind the stricture, is pure imagination. You will see this condition quite commonly in strictures of large caliber as in those of small caliber. It does not start with a rupture of the urethra. In most the trouble begins behind the stricture; but it may start in front of the stricture. It is a gangrenous periurethritis starting in a condition of chronic urethritis. Chronic urethritis involves a glandular infection, those glands lying always, as you know, in the submucous connective tissue. Most commonly this disease will occur in men in poor general condition because of urinary obstruction, renal insufficiency, and the things which go with it. That I believe to be the explanation of the fact that these cases commonly occur in later life, when the late results of moderate degrees of urethral obstruction have taken place.

I have no basis for discussing the condition of the prostate. On the other hand, I

*Published in THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION with the permission of the Massachusetts General Hospital.—Ed.

should like to point out to you at this time that hypertrophic adenomatous changes of the prostate do not often take place behind the stricture. If you wish to insure a man against having an enlarged prostate, the best way is to see that he acquires a gonorrheal infection, with a resulting stricture and chronic prostatitis. Probably the reason for this is that the mis-called hypertrophy takes place only in certain glands, groups of which lie along the sides of the urethra, in the lateral lobes, and along the posterior floor of the urethra in the median lobe, and under the neck of the bladder as described by Alberan. These glands lying close to the urethra are sure to be involved in chronic prostatitis. I give you that not as a scientific explanation but as a possible explanation of the fact, a fact which we have verified in a large number of cases. When you see men described as having hypertrophy of the prostate and stricture at the same time you may assert that they have not. You can lay it down as a general rule which has few exceptions that if you know a man's prostate is hypertrophied, he has not got a stricture. Whether traumatic stricture of the urethra will produce this picture I am not sure. We see traumatic stricture with less frequency. So that as a prophylactic for the avoidance of hypertrophy of the prostate I can only advise the acquisition of an inflammatory stricture.

These people with gangrenous periurethritis are overwhelmed with an infection, temperature commonly subnormal, though it may be high, pulse weak and rapid. They do not stand prolonged operation. Operation must be planned to move fast. On the other hand, like all the moist gangrenous processes you must go to the limits of the disease or you will do no good. No matter where the gangrene goes, you must follow it if you split them from stem to stern, from backbone to anus. You must follow the process. Commonly you will start with a median incision which will take you into the most active part of the process and generally into the urethra. The urethra in that portion is commonly gone. But the process never involves the

urethra behind the triangular ligament. The deep urethra will never be involved. It has a separate blood supply at the triangular ligament. So the urethra can always be found without difficulty. It is generally dilated behind the stricture. You will commonly find it necessary to split the scrotum, follow the process into one or both groins until you get into normal tissue, dissect up your flaps until all the edema is exposed, put a tube in the bladder, and pack the wound open. Commonly this operation can be satisfactorily done under spinal anesthesia. These people do not stand well a general anesthesia, but a whiff of gas may see you safely through. Your operation must be characterized by boldness and speed.

I will make a diagnosis of acute gangrenous periurethritis, mis-called infiltration of urine.

DR. CABOT'S PRE-OPERATIVE DIAGNOSIS

Acute gangrenous periurethritis.

PRE-OPERATIVE DIAGNOSIS

Gangrenous periurethritis.

OPERATION

Spinal apothesis. The whole perineum and inferior portion of the scrotum, extending out on the buttocks, were gangrenous. The patient could not be catheterized. A small sound was passed and a median perineal incision was made through the gangrenous bulb. The urethra was opened. A large catheter was passed to the bladder and about 5 xx of concentrated urine withdrawn. Four other incisions were made in the perineum and buttocks for drainage. The gangrenous tip of the scrotum was cut off. Quarter-inch rubber tubes were placed up towards the inguinal canals for drainage. The tissues were edematous and gangrenous.

FURTHER DISCUSSION

The interesting questions involved are as to how much damage has resulted to the kidneys, whether this was a death from renal insufficiency with intercurrent pneumonia

and that pneumonia very likely basal, or whether we are dealing with arteriosclerosis and septicemia with the terminal infections which take place. I see no data here by which I can decide as to the condition of the kidneys. There is no examination of the urine to go by; there is no description of the urine as being foul or particularly purulent; so I doubt whether we are justified in assuming that there was much damage to the kidneys. I think it better to take the other horn of the dilemma and assume that here is a man with arteriosclerosis, in other words old, and that he has a very severe infection. He has been able to manage it with some success locally, but unable to shake it off as a general process. There should be found pneumonia of some grade; but as we have no examination of his lungs to guide us we cannot say that he is going to have consolidation at the bases, wet lung, which these people so commonly have, or that he will have a definite lobar pneumonia or bronchopneumonia. I am inclined to use the phrase hypostatic pneumonia for him, and think that there will be found at necropsy hypostatic pneumonia, arteriosclerosis, hypertrophy and dilatation of the heart, hypertrophy and dilatation of the bladder shown by trabeculation and thickening of the wall. Probably pretty sound kidneys will be found. There will be extensive gangrene of the bulbous urethra, considerable gangrene of the surrounding tissues as described in the operation, and septicemia from an organism which I cannot undertake to predict.

CLINICAL DIAGNOSIS (FROM HOSPITAL RECORD)

Ruptured urethra.
Gangrenous periurethritis.
External urethrotomy for urethritis.

DR. HUGH CABOT'S DIAGNOSIS

Acute gangrenous periurethritis.
Hypostatic pneumonia.
Arteriosclerosis.
Hypertrophy and dilatation of the heart.
Hypertrophy of the bladder.

ANATOMICAL DIAGNOSIS

1. Primary fatal lesion:
Gangrene of the subcutaneous and deep tissues in the region of the urethra with sloughing of the wall of the scrotum.
2. Secondary or terminal lesions:
Slight cystitis.
Acute ulcers of the stomach.
Hemorrhage into the stomach and intestine.
Anemia.
Edema, lower lobes of lungs.
3. Historical landmarks:
Chronic pleuritis.
Arteriosclerosis, moderate.
Hypertrophy and dilatation of the heart, slight.

DR. RICHARDSON: Is there anything in the history indicating bleeding from the mouth?

DR. YOUNG: Not a thing.

DR. RICHARDSON: The prostate and kidneys were negative. The general condition showed anemia, and there was hemorrhage into the stomach and intestine. As the anatomical basis for that we find the mucosa of the stomach generally diffusely reddened, the organ containing 500 c. c. of smaller and larger masses of blood clot and bloody fluid, and on the posterior wall of the cardia several small erosions. Evidently the bleeding had come from those erosions. Microscopical examination showed them to be acute ulcerations, and in one of the sections the wall of a small artery was apparently eroded and involved in the inflammatory process. So that so far as the examination here goes, the bleeding was probably due to that.

The cultures from the blood stream showed colon bacilli.

DR. YOUNG: There is a great deal of question about the point I made that anaerobic bacilli are necessary to cause extensive gangrene. Some people contend that any bacillus, even the colon, can make this amount of trouble if the soil is right and the individual right.

DR. RICHARD CABOT: Can you tell us a little more about those acute ulcers of the stomach?

DR. RICHARDSON: They were of the acute, eroded type, inflammatory processes, and in one section apparently involved the wall of a small vessel and in three or four areas the blood apparently oozed.

DR. RICHARD CABOT: Do you find them in septicemias?

DR. RICHARDSON: We find rather constantly with septicemias lesions presenting something after this fashion: we find in many instances hemorrhagic areas scattered along the intestinal tract, more or less soft and oozing bloody material. A step further and necrosis is more apparent; a step further and they seem to have eroded through. It is true that in many cases, especially in regard to the stomach, we have to be very cautious that they are not due to post-mortem solution. But I have seen it so often that I think a certain amount of it is due to sepsis—inflammatory processes of the wall of the gastro-intestinal tract, softening, hemorrhage, and in some cases perforation.

DR. RICHARD CABOT: Does that occur in the esophagus too?

DR. RICHARDSON: We find them in the esophagus too. In a number of cases, some of them diseases of the nervous system, where the tone of the tube has been lowered, we find hemorrhagic areas, areas of softening, and perforation. In some cases there seems to be inflammatory reaction about the region of the wall, and in these cases where there is this reaction I think without any question they occurred during life. In some of the others it is not quite so clear. It might be post-mortem or a combination of the two. But in many of the cases I think they are lesions that occurred towards the end of life. They might be said to be something of the nature of bedsores of the gastro-intestinal tract.

DR. RICHARD CABOT: Do you suppose they can arise in the same way that acute endocarditis does in a septic case, an ulcer forming on top?

DR. RICHARDSON: Yes; I think that is possible. That etiology of ulcers is claimed by some to be that of the peptic ulcers. I think in this case it is a septic inflammatory process of the gastric mucosa which we find not infrequently in the gastro-intestinal tract in cases of sepsis. In one case, a staphylococcus septicemia, I found what were undoubtedly small abscesses in the mucosa of the colon.

DR. RICHARD CABOT: The whole question of ulceration of the stomach is not clear in text books and reports in medical journals as soon as we get beyond the perfectly familiar peptic ulcer of the stomach and duodenum. They speak of medical ulcers, mucous ulcers, all sorts of things that are not recognized pathologically and that we have no definite knowledge of. The only thing we have knowledge of is the peptic, deep-seated ulcer of the stomach and duodenum, and therefore when we get some post-mortem evidence on the nature of acute ulcers I am very eager to know what it is. It is a matter that interests every student, and every bit of evidence from this end is valuable.

DR. HUGH CABOT: There has been a tendency to regard ulcer of the stomach as secondary to a lesion of the appendix and a lesion of the appendix secondary to an ulcer of the stomach. I have never been able to follow that line of reasoning at all. It seems to me very likely that these two things are on the same basis, that they are tails of the same cat, the cat presumably an infection, and the infection may start with a definite abscess in the submucous connective tissue. The same process which causes the appendicitis, particularly the chronic appendix, may very well be at the bottom of the gastric or duodenal ulcer. But that has no bearing upon the case.

Here is an accidental complication of which he probably died and without which he probably would not have died. His wound was clean, his kidneys were apparently sound enough, and his arteriosclerosis not of very high grade. Therefore if this outside complication had not come in he would probably

have recovered. I do not see how the ulcer with resulting hemorrhage could have been diagnosed during life.

TUBERCULOSIS RESEARCH FELLOWSHIP.

University of Minnesota.

To encourage study of the means for the prevention and cure of tuberculosis, the Hennepin County Tuberculosis Association of Minneapolis, Minn., announces that it has set aside a fund for the support of a tuberculosis research fellowship in the Graduate School of the University of Minnesota. The candidate for the fellowship must be a graduate of a Class A medical college. He will be expected to devote himself to research in some problem concerned with the causes, prevention, or cure of tuberculosis. No teaching or other service will be required. The fellowship yields \$750 the first year and progressively increasing amounts to be appropriated for the second and third years as conditions warrant. Inquiries and requests for application blanks should be addressed to the Dean of the Graduate College, University of Minnesota, Minneapolis, Minn.

NEW AND NONOFFICIAL REMEDIES.

ICHTHYNAT. — An aqueous solution, the important medicinal constituents of which are ammonium compounds containing sulphur in the form of sulphonates, sulphones and sulphides. These characteristic forms of sulphur result from the sulphonation of the tarlike distillate obtained from certain bituminous shales. For the actions and uses of ichthynat see the general article on Sulpho-ichthyolate Preparations and Substitutes, New and Nonofficial Remedies, 1920, page 318. The Heyden Chemical Works, New York City. (*Jour. A. M. A.*, Oct. 2, 1920, page 939.)

PROGANOL. — A compound of silver and albumose, containing not less than 8.3 per cent of silver in organic combination. For the actions and uses of proganol, see general article on silver preparations, New and Nonofficial Remedies, 1920, page 306. From 0.25 to 1 per cent solutions are used in acute gonorrhea, and 5 to 10 per cent instillations in chronic cases. In cystitis and urethritis from 1/1,000 to 1/2,000 solutions are used as irrigations. Used also in forms of bougies and tampons (5 to 10 per cent).

PUBLISHER'S NOTES

AROMATIC CHLORAZENE POWDER.

Influenza may or may not be rampant this winter as it was last year and the year before. It is probable, however, that the disease will make its appearance again, as forecasted. We shall see. The one thing we may be sure of now is that there will be plenty of rhinitis and other manifestations of localized infection affecting the upper respiratory tract, including the sinuses. To the lay persons they are "colds," distressing more or less, causing some malaise and some fever along with the local symptoms, and showing evidence of being transmissible or epidemic.

In view of this the newer Dakin chlorine compounds will interest us, as applied to the nose and throat for the purpose of disinfecting these passages against disease germs.

Whether effecting against the development of the influenza organism is questioned by some but against the milder agencies concerned in epidemic winter colds, it is fair to assume that much good may come from the use of germicidal solutions so employed.

Aromatic Chlorazene Powder serves well for washing out the nasal and oral passages. It contains the chlorine compound to the extent of 5 per cent, with desirable alkaline sodium salts and eucalyptol added. Freely soluble in water, fluids for douching or spraying are readily made as they are needed. Its germicidal value is not a fancied one. Weight for weight this powder is about 2½ times stronger than phenol. Hence, for office treatment in catarrhal conditions generally affecting the nose and throat, Aromatic

Chlorazene Powder is a most satisfactory recourse. The Abbott Laboratories, Chicago, will supply it. A sample vial may be had by those who care to try it out.


THE TREATMENT OF SHOCK.

That the surgeon has in Adrenalin a dependable means of combating shock has been known to the profession for a number of years. As long ago as 1909 Mummery and Symes announced their observations on the effects of Adrenalin upon the blood pressure and recommended its use by the slow and continuous injection of a very weak solution into a peripheral vein. They also found that the action of Adrenalin is enhanced by the coincidental administration of pituitrin, this procedure producing a more marked effect in shocked animals than in normal subjects.

In our advertising section, under the title "Adrenalin in Medicine," will be found a brief review of the plan of treating shock with highly diluted solutions of Adrenalin Chloride, by intravenous infusion and by "centripetal arterial transfusion," after the method of Crile.

This little essay is the third of a series of concise and informative papers published in

this rather unconventional form by Parke, Davis & Co. We have no hesitation in commending these meritorious articles to the consideration of our readers.



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ORIGINAL ARTICLES

THE TREATMENT OF INFLUENZA PNEUMONIA.*

STANLEY ERWIN, M. D., AND
LOUIE LIMBAUGH, M. D.,
Jacksonville, Fla.

In selecting the above subject for this paper we realize the large scope we are endeavoring to cover and the rather indefiniteness of terminology. The reference, "Influenza Pneumonia," has been used because we wish to discuss some of the fundamental principles of treatment of this infection, whether by physical signs or clinical observations the case be a lobar- or broncho-pneumonia. Regardless of the type and extension of the inflammatory process in the lungs, all clinicians probably agree that the pneumonic process developing in a case of influenza is usually of a type different from the former classical conception of pneumonia. The infection has as a rule been intense and the toxemia and general debility have been in far greater proportion than the apparent extent of the pulmonary involvement would lead one to expect.

It will not be attempted here to elucidate the unusualness of the clinical picture of these types of cases or to delve into their pathology. We do wish to offer a few remarks concerning the more useful therapeutic agents employed in combating this malady of such high mortality, for which by no means has any satisfactory therapy been demonstrated, with special reference to the use of intravenous administrations of hypertonic glucose solutions.

Certainly no remedial agent has been found which offers an infallible aid in treating these cases unless we place the opiates in

this class. For the painful cough, pleurisy, insomnia or restlessness, no drug can be used to more advantage than opium; and morphine is the most satisfactory preparation. In delirium, where the patient gets no relaxation for hours, morphine in one-sixth to one-quarter grain doses hypodermatically will enable the patient to use his forces and strength in combating the infection instead of wasting his reserve powers in struggles and restlessness. It is well to combine atropine with the morphine, as the former combats any depressant effect the morphine might have on the respiration. Many observers object to morphine, but the writers cannot but feel that it has a very prominent place among the therapeutic aids in this disease.

Quinine has been found to have a definite pneumococcidal action and in some cases has been shown to be of definite practical value. In instituting quinine therapy, it is best given early in the disease and should be administered regularly and persistently. Since it is frequently impractical to give a patient, seriously ill with pneumonia, a capsule of quinine three or four times daily, the drug is best administered as the dihydrochloride obtained in solution in sterile ampuls. In this form, two grams should be given in the first twenty-four hours and then at least one gram daily until there is a general improvement in the condition of the patient and a subsidence of toxemia. Quinine sulphate may then be given by mouth in five-grain capsules every four hours. The quinine dihydrochloride is given by intra-muscular injections and great attention must be paid to the technic so that none of the solution gets into the subcutaneous tissues instead of muscular tissue, otherwise a quinine slough may occur and the resultant ulcer is extremely slow in healing.

*Read before the Forty-seventh Annual Meeting of The Florida Medical Association, at Daytona, May 12, 13, 1920.

As to the use of the serums and vaccines, when a case can be typed out and is found to be a Type 1 pneumococcus infection, Type 1 serum may be given with reasonable expectations of beneficial results. Serums in the Types 2, 3 and 4 infections have not proven satisfactory. The writers do not indorse the treatment of influenza pneumonia with the various vaccines now advocated in some sections.

Certainly the coal-tar derivatives, used so extensively in the treatment of influenza, should be stopped as soon as it is ascertained by the clinical picture or physical signs that a pneumonia has developed, as their depressant action on the circulation is probably beyond dispute.

It is the poor quality of the circulation and usually marked degree of cyanosis that is so frequently seen in these cases. The extreme toxemia, weak pulse and cyanosis develop so rapidly at times that many physicians put their cases on digitalis early in the disease so as to be prepared in a way to offer support to the heart. Digitalis is an apt aid, but how many of us are able to obtain a standardized, fresh preparation for administration? So often, too, the wait of twenty-four to sixty hours for the effect of digitalis is most trying. By use of the method of Eggleston¹, one can rapidly get the effect of the drug, but even under digitalis the cyanosis may still be considerable, for this condition results from the toxemia plus other unknown factors rather than simply from a poor circulation *per se*.

In the use of intravenous injections of hypertonic glucose solutions we have a means of frequently considerably lessening the toxemia with the coexisting restlessness, semi-delirium or stupor, and of improving the quality of the pulse as well as lowering its rate. The action of glucose in these respects is not peculiar to pneumonia. Litchfield² has reported its use with good results in streptococic septicæmia, epidemic meningitis and other conditions of marked dehydration. Erlanger and Woodyatt³ have demonstrated its value in certain phases of

shock. Its use in influenza pneumonia was extensively studied in a series of 319 cases by Wells and Blankinship⁴. They used solutions of 10, 15, and 25 per cent strengths in different series of cases. The writers have used a 10 per cent hypertonic solution of glucose intravenously in a small series of cases of influenza pneumonia, and wish to outline the method of preparation and technic of injection of the solution with some comments upon the theoretical action and practical results obtained.

PREPARATION OF THE SOLUTION.

One hundred grams of chemically pure glucose were dissolved in 1,000 cubic centimeters of distilled water, bringing the solution slowly to the boiling point so that the glucose might be thoroughly dissolved. The solution was next filtered through a heavy layer of cotton and then brought up to its original volume with distilled water. It was then autoclaved at twenty pounds pressure for twenty minutes, filtered through several layers of filter paper and again brought up to its original volume with distilled water. The solution was then equally divided into four flasks of 250 cubic centimeters each. These flasks were properly stoppered with gauze and cotton and autoclaved as before, after which they were ready for use. The filtrations are important: the first removes any gross contamination, the second removes such precipitation as sometimes occurs after autoclaving. The solution when finally prepared should be perfectly clear.

TECHNIC OF INJECTION.

The apparatus used for injections is the same as for administering arsphenamine by the gravity method. Any suitable vein, usually one in the antecubital space is selected. Two precautions are advised: First, the solution should enter the vein at a temperature slightly above that of the normal body. This condition is successfully met with by placing the rubber tubing in a basin of warm water during the injection. Second, the solution should be introduced into the blood streams very slowly, not over 90 drops per

minute. This may be conveniently accomplished by the use of a pinch cock on the tubing below which was inserted an ordinary glass Murphy drip bulb. In this manner the flow of the solution may be easily measured by drops per minute and is under convenient control.

Due to the slowness of the flow of the injection, a needle of sufficient size to prevent clotting should be used. We have used a Schrieber needle with very satisfactory results. 250 cubic centimeters were injected daily until the temperature reached normal or all toxic symptoms cleared up. This treatment was instituted when evidence of severe toxemia became manifest, usually within the first three days of the disease.

THEORETICAL ACTION OF THE GLUCOSE SOLUTION.

Being a hypertonic solution, there is at first a dehydration of the tissues of the body with consequent elimination of toxins from the body cells. The glucose is in turn at once and rapidly absorbed by the tissue cells with a resultant transversion of the flow of fluids. Thus the fluid intake of the patient is increased by several hundred cubic centimeters of water daily. Glucose itself acts not only as a food but is a stimulant to individual cell activity. It has been suggested in this roll that it acts as a direct stimulant to the cardiac muscle fibers. The renal activity is increased.

PRACTICAL RESULTS AFTER GLUCOSE INJECTIONS.

The degree of cyanosis is usually lessened. The toxemia with coexisting restlessness, semi-delirium or stupor, and anxiety is lessened considerably. The pulse is improved in quality and its rate slowed. The degree of temperature is lowered and the duration of the febrile period is apparently shortened. Certain so-called protein reactions with marked temporary elevation of temperature have been described following glucose injections, but have never appeared detrimental. On the contrary, Wells⁵ reports a series of cases of influenzal pneumonia in which he injected intravenously, macerated, alcohol-

dried typhoid bacilli suspended in physiologic sodium chlorid solution, in doses sufficient to produce protein reaction and with encouraging results.

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VALUE OF X-RAY IN THE DIAGNOSIS OF PULMONARY TUBERCULOSIS.*

A. H. HIGGINS, M. D.,
Tampa, Fla.

The time allotted is so short that it is impossible to consider this subject fully. It has been selected not to show the value of the X-ray alone but to demonstrate its inestimable value when used in conjunction with a careful consideration of the clinical symptoms and physical findings. Only in advanced cases can a diagnosis of pulmonary tuberculosis be made from the radiogram, and even then the degree of activity can only be determined by the clinical symptoms. The X-ray does not disclose infiltrations of the very early tubercular lesion. Caseated areas and airless areas are clearly revealed. Whether these lesions are tubercular in nature and whether the lesion is active can only be determined by clinical methods.

The radiogram is a record of the history of the lung. Pathological changes that have occurred at any time during the life of the patient leave their traces. The X-ray helps materially in discovering changes in the

*Read before the Florida Midland Medical Society, at Orlando, October 13, 1920.

thoracic cavity which formally escaped notice during the life of the patient. This is true of deep-seated lesions such as pleural adhesions, enlarged bronchial glands, small cavities in the lung, localized pneumothorax, abscess and gangrene. In the average early case of pulmonary tuberculosis auscultation and percussion will reveal the condition at the site while no lesion will be shown by the radiogram. Many roentgenologists claim that an early tuberculous process is distinctive, without taking into consideration that other infections of whatever character spread as a rule along the course of the air passages. These conditions produce a thickening of the fibrous sheaths of the bronchi, blood and lymph vessels. In these cases an etiological diagnosis must be made. The clinical evidence and physical signs may be inconclusive and equally so the radiogram. It is only when the tubercular lesion has advanced that definite opinions can be expressed.

Another point to bear in mind is that the roentgenologist cannot from the radiogram determine whether the lesion is active or inactive. In the early use of the X-ray in tuberculosis much attention was attached to the hilus shadows, "visionary shadows," as Osler termed them. Improvement in the technique has eliminated false shadows.

We lack anatomical corroboration of X-ray findings. It was upon anatomical proof that physical diagnosis was founded. Such proof can only be furnished by combined observation of the clinician, the radiographer and the pathologist.

Although the value of the X-ray in early diagnosis is still to be proved, there is no question as to its advantage in determining the extent of the lesion.

The examination must be made in a systematic manner first by the fluroscope and then the radiogram. With the fluroscope and an open diaphragm both lungs must be compared. The symmetry of the forms, contours and dimensions must be noted as well as the mobility of the organs and their regularity in functioning. Now the apices, hilus, sinuses,

interlobes and diaphragmatic respiration must be examined in detail. Analyzing the shadows and mottlings in incipient cases admits of many interpretations that are of doubtful utility. Very often the fluroscope will disclose information of a positive nature and the radiogram show nothing of importance. In incipient cases or cases where the activity or inactivity of the lesion is of paramount importance the X-ray fails when taken alone, but in conjunction with the clinical symptoms and physical findings the addition is invaluable.

In conclusion I wish to urge the use of the complete X-ray examination in conjunction with a careful study of the clinical symptoms and physical findings. Our aim should be the use of every means at our command that will enable us to diagnose the incipient case. The advanced cases are easily recognized by the X-ray findings. But even these cases demand a careful painstaking clinical and physical examination.

CASE RECORDS.*

(ANTE-MORTEM AND POST-MORTEM) AS USED IN WEEKLY
CLINICO-PATHOLOGICAL EXERCISES AT THE
MASSACHUSETTS GENERAL HOSPITAL

EDITED FOR THE USE OF PRACTITIONERS BY

RICHARD C. CABOT, M. D., AND

HUGH CABOT, M. D.

F. M. PAINTER, ASSISTANT EDITOR

CASE 6172.

An American watchman of sixty-two entered January 2.

F. H. Unimportant.

P. H. Negative except for possible typhoid fever at ten years and rare urination at night.

P. I. Three months before admission he noticed a swelling on his lower jaw as large as a thimble. Three weeks later he went to a physician, who gave him some salve. During the past week he had had a great deal of continuous pain and had slept very little.

P. E. He was well-nourished. The mucosæ was rather pale, the scleræ yellowish. There was arcus senilis. The chest was barrel

*Published in THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION with the permission of the Massachusetts General Hospital.—ED.

shaped. The expansion was greater on the left than on the right. The *lungs* were normal except for a few rales in both backs. The *heart, abdomen, genitals, extremities, pupils* and *reflexes* were normal. *Local*: On the right side of the lower jaw was a mass about the size of an orange, apparently not attached to the mandible, but extending down the neck. The skin above appeared normal.

Before operation *T.* 96.1°-99.9°, *P.* 67-87, *R.* normal; systolic *B. P.* 130, diastolic 75, amount of *urine* not recorded, sp. gr. 1014, other findings negative; *blood* normal. *Wassermann* negative. *X-ray*: The lower jaw from the symphysis to the angle presented no definite evidence of pathology. Rami not shown. No positive evidence of pulmonary metastasis.

January 7 operation was done. Next day the patient had not recovered consciousness. His temperature rose to 104° (rectal), the pulse to 120, the respirations to 35, stertorous, the blood pressure to 165 systolic, diastolic 60. A neurological consultant reported, "Pupils small. Weakness of right jaw. Possible left internal rectus palsy. Spasticity of the arms and legs easily overcome giving way rather abruptly—paralysis or paresis? Condition of cranial nerves not made out. Possible embolus of basilar artery."

Early the next morning the patient died.

DISCUSSION

BY DR. HUGH CABOT.

The description is a little meagre; but it is pretty clear we cannot regard this as a tumor primarily of the jaw. We must assume it comes from the soft parts overlying the jaw; and as the skin is not broken or involved in any way, it probably comes from the deeper parts and is of glandular origin. There is a little fever, not more than you commonly get with malignant disease. It does not help in deciding between an inflammatory or malignant mass. There is nothing in the description, however, which suggests an inflammatory condition. It is unusual to have the skin move freely over an inflam-

matory mass unless that mass is glandular and confined entirely to the glands themselves without having broken through at any place. Even in tuberculous glands, while practically confined to the gland substance, the skin is more or less fixed. On the other hand malignant tumors in this region much more commonly spring from the jaw than from the deeper tissues. While they say it is not attached to the jaw, I think one must believe that what they mean is that it is not of bony origin. One might assume that it arises from the periosteum and is not part and parcel of the jaw itself, and therefore the X-ray does not show changes in the bone. I think the most probable diagnosis here is a sarcoma originating from the periosteum of the jaw.

Operation is probably indicated, but likely to be pretty mutilating. If the mass arises from the periosteum it is of no use to do less than remove the jaw from the midline to the angle. Then again the triangles of the neck on that side ought to be cleaned out. It is a big dissection with not a first class chance of success. Very often in order to do the dissection satisfactorily you have got to tie the common carotid, and that is occasionally a serious business. He ought to know what he is in for. I do not personally go into this kind of operation with the hand playing.

DR. CABOT'S PRE-OPERATIVE DIAGNOSIS.

Sarcoma, probably from periosteum of the jaw.

PRE-OPERATIVE DIAGNOSIS.

Carcinoma of the neck.

OPERATION.

Ether. Two-inch transverse incision on the right neck. Stab wound. — A cyst was tapped and about 144 c. c. of reddish slightly mucoid but nearly clear fluid was extracted. The tumor was then cut down on and a small section removed from the wall of the cyst for diagnosis. The tumor was grayish red, hard and gristly. The inside was black and shaggy as if necrotic, and across it ran a few trabeculæ, one of which was tied and cut. The wound and the cyst were packed with gauze and the skin closed with a drain at the middle

of the incision. The patient was in poor condition from the beginning of the operation until the end.

PATHOLOGICAL REPORT.

Microscopic examination shows a cellular connective tissue infiltrated by an interlacing network of atypical epithelial cells, some of which are cornified.

Metastatic epidermoid carcinoma.

H. F. HARTWELL.

FURTHER DISCUSSION.

All they did was to drain some fluid out of a cyst of unknown origin and take out a specimen. It could have been done under local anesthesia. I can see no reason for giving ether, which is the worst possible anesthetic for this man with scattered rales through his lungs.

It is interesting, showing that in people of this age you ought to go pretty cautiously about an operation of any kind and particularly operations of the head and neck. This was a pretty inoffensive operation; yet it was followed by, though perhaps it should not be said to have caused, death. There is some evidence, insufficient to a diagnosis, but some evidence of intracranial difficulty here which may have been consequent upon operation, or may be some type of cerebral hemorrhage or embolism such as might have occurred without any operation at all. There was not present any important evidence of arteriosclerosis; and yet arteriosclerosis is so common in men of that age that one may almost assume it. This condition may be a sequel of the anesthesia, or a sequel of the operation, though as they describe the operation it is hard to say how that could produce this condition except through the medium of anesthesia.

I am not at all clear that anything will be found in the head to account for this condition. You see in these people with arteriosclerosis transient conditions which if they live disappear, and if they die are likely to be taken more seriously than is necessary. His temperature might of course be due to some intracranial difficulty. It might also be due

to some infection in his wound, kicking of the hornet's nest, which is likely to happen with surgery in the neck. There is evidence here of a weak heart, pulse of over 100, suggesting that this cardiovascular system was in a good deal less satisfactory condition than they had supposed; and there probably will be found soggy bases to his lungs. I should not be surprised if there was nothing in the head to account for this. There may very well be found a septicemia which accounts for the whole.

CLINICAL DIAGNOSIS (FROM HOSPITAL RECORD).

Carcinoma of the neck.

Cerebral embolus.

Incision and drainage of tumor of the neck.

DR. HUGH CABOT'S DIAGNOSIS.

Operation on neck.

Arteriosclerosis.

Hypostatic pneumonia.

No brain lesion.

ANATOMICAL DIAGNOSIS.

1. Primary fatal lesion:

Chronic interstitial hepatitis.

2. Secondary or terminal lesions:

Carcinoma of the neck, primary in a branchial cyst.

Operation wound.

Hypertrophy of the spleen.

Icterus.

Slight ascites.

Cholelithiasis.

Hemorrhagic edema of the lungs.

Arteriosclerosis.

Hypertrophy and dilatation of the heart.

Arteriosclerotic nephritis.

Wet brain.

3. Historical landmarks:

Mucocele of the appendix.

Ulcers of the stomach.

Slight chronic pleuritis.

DR. YOUNG: What would that pathological report of carcinoma imply as to possible primary focus?

DR. RICHARDSON: I found tumor tissue only in the region of the neck. It looks as if

it might be one of those tumors which arise in a branchial cyst and which are congenital. I did not find any metastases. If there were metastases they would extend from the tumor of the neck to other places.

There was probably a little arteriosclerotic nephritis.

DR. YOUNG: It is a very good example of focussing attention on one thing and missing a good many others. I do not see how it was possible to miss some of those things. They did say the sclerae were yellowish, but otherwise there was no mention of large spleen or ascites or anything at all indicating liver damage.

TUMORS OF NECK. OUTLINE.

BY DR. EDWARD L. YOUNG, JR.

1. Goitre.
 - A. Hyperthyroidism.
 - B. Cystic.
 - C. Neoplastic.
2. Infectious origin.
 - A. Chronic.
 - (a) Sepsis due to absorption from teeth, tonsils, pediculosis.
Common in childhood, and especially where environment is unhygienic.
 - (b) Tuberculosis.
More common in childhood, but seen in adults.
 - (c) Actinomycosis.
Rare.
 - (d) Syphilis.
 - B. Acute.
 - (a) Phlegmon of neck.
 - (b) Vincent's angina.
 - (c) Mumps.
 - (d) Suppurative parotitis.
3. Neoplastic origin.
Generally in "cancer age."
 - A. Tumors of parotid (mixed tumors).
 - B. Carcinoma.
Arising from any of epithelial-lined areas or from carotid gland.
Metastatic (on left can come from a distance).

C. Hodgkin's disease.

D. Rare bursal and lymphatic cysts.

4. Congenital origin.

Uncommon. Generally appearing in childhood or early adult life.

A. Branchial cysts (always lateral).

B. Thyroglossal cysts (always median).

NOTE BY DR. CABOT.

That is the kind of man-trap which is set for you all the time. A patient will come with some obvious difficulty, a boil or abscess or cancer of the lip, and you will be inveigled into operating upon him without a thorough physical examination. I have tried for years to get it into the heads of my house surgeons that they must examine all their surgical patients just as if they were medical patients. They hand you, for instance, a case of hemorrhoids and you find chronic hepatitis. It seems as if they ought to have been able to recognize a good deal more of the arteriosclerosis, ought to have recognized him as a fairly bad surgical risk. It seems obvious that this man was no subject for a surgical operation which stood no chance of curing him. The condition would have been serious in a much younger and sounder man; and unless it could be shown that this man was in exceptionally good condition or that this malignant mass in the neck was unusually curable by operation, surgery was in the wrong place in attempting to deal with it. I think one must regard it as bad judgment to have operated upon this man at all.

THE LETTER BOX.

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION has stressed from time to time that its columns are open to all members of the association, not only in publishing original articles, but to publish communications on pertinent subjects of interest to the profession of the State. The editor on more than one occasion has made earnest effort to secure an expression of opinion concerning questions that it would seem should interest the members. Only recently two editorials appearing in successive numbers of THE JOURNAL and over a hundred letters directed

to members known to be engaged in special work reaped a harvest of thirty-two replies.

Organized medicine throughout the country—including Florida—is going to face in the near future matters of vital interest to the profession. Active organizations will be able to accomplish much where the passive ones will fail.

The Letter Box is therefore inaugurated as a feature in this issue, with the hope that it will become a permanent one, an attractive one, and one that will result in benefit to the profession of the State individually and collectively. If you have a suggestion to make at any time concerning either improvements in *THE JOURNAL* or policies of the association, write and tell us about it. If you are modest and do not wish your name to appear in print, write under a nom de plume; we will respect your wishes, simply requiring to know from whom the article comes as an evidence of good faith. We are pleased to publish in our first Letter Box the following:

FLORIDA

STATE BOARD OF HEALTH

RALPH N. GREENE, M. D., State Health Officer
EXECUTIVE OFFICE, JACKSONVILLE

DECEMBER 2, 1920.

Dr. Graham E. Henson, Editor The Journal of the Florida Medical Association, Consolidated Building, Jacksonville, Florida.

DEAR DR. HENSON—Attached herewith is a communication in the form of a resolution by the Guilford County Medical Society of North Carolina, together with a copy of reply of the State Health Officer of North Carolina.

Will you kindly give this matter consideration and make same the subject of editorial comment or a special article in the *JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION*?

It seems to me that this proposition is one that is coming to a climax in Florida, as the State Board of Health is rapidly assuming activities very similar to the activities of the State Board of Health of North Carolina.

We are now doing trachoma work and school examination work and of course have been doing hookworm work, malaria eradication and treatment of indigent venereal cases.

We contemplate putting on tonsil and adenoid work soon after the first of the year and possibly free dental work.

I have addressed a communication to the president of the Florida Dental Society asking his opinion as to the advisability of doing this free dental work on the ground that it will be done where dental work is not ordinarily done, and after cases have once been to the dentist it has been found elsewhere that the dental education actually makes more work for the dentists.

I feel, also, that with the public becoming more and more enlightened about public health affairs and medicine, generally, activities of the State Board of Health will not only not interfere with the practice of private physicians, but it will rather increase their work.

I have just sent out a communication to the doctors of the State asking for information and opinions about proposed plans for reorganization of the State Board of Health, and if you can, at this time, give considerable space to an article dealing with the subjects mentioned, I am sure that you will accomplish a great good.

Thanking you in advance for your consideration of this important matter, and requesting that you return the file of correspondence from the North Carolina Board of Health after you have finished with same, I am,

Sincerely yours,

RALPH N. GREENE,
State Health Officer.

On November 4, 1920, The Guilford County Medical Society passed the following resolutions, a copy to be sent to the secretary of each County Medical Society and to the secretary of the State Board of Health:

1. We heartily endorse the Educational Campaign which has been instituted by the North Carolina Board of Health and which has been successfully conducted by them for a number of years. We believe that this Campaign of Education, as instituted by the State Board of Health, has done much to stamp out infectious diseases and has prevented the spread of communicable diseases. The education of the people along health lines has saved a great number of lives.

2. We do not believe that the State Board of Health should institute a treatment campaign for any disease or condition. The physicians of North Carolina, who are licensed to practice by the constituted Board of Examiners, are fully qualified and in number sufficient to take care of the indigent sick and none will suffer for want of medical attendance.

3. The campaign instituted by the State Board of Health for the removal of tonsils and adenoids has been unnecessary, expensive and reflects upon the willingness of the physicians of the State to take care of these cases. In the main, the cases that have been operated on have been at places unsuited for operations on the throat or any other surgical procedure. Operations conducted in school houses or places that have not been especially constructed for this and in the presence of a great number where the patient could not have the best advantages, are conducive to bad results, and owing to the congestion incident to these clinics, in many instances, are dangerous to life. In Guilford County the men doing special work along this line have always been anxious and willing to give to any poor person, who may need their service, every consideration and their best efforts free of all charges, but these men are not willing to operate on cases that are able to pay without compensation, and indeed we believe that the local men are more familiar with the financial conditions existing in this community than the State Board of Health.

4. We believe that every operative case should be studied and a complete examination made and a careful history taken, then treated when the operator is not forced to tax himself or his assistants, avoiding excitement, rush and a wholesale way of doing things.

5. The treatment of diseases as instituted by the State Board of Health is looking toward socialistic

medicine animated by a socialistic spirit and is a step toward State paternalism, to which we emphatically object.

6. A committee is appointed to confer with the State Board of Health and with the legislative committee of the North Carolina State Medical Society in anticipation of the proposed medical section of the Workmen's Compensation Act.

NORTH CAROLINA
STATE BOARD OF HEALTH
EXECUTIVE OFFICE

RALEIGH, November 24, 1920.

Dr. J. F. Pate, Secretary-Treasurer, Guilford County Medical Society, Greensboro, N. C.

DEAR DR. PATE—This is to acknowledge the receipt November 18th of the resolutions adopted by the Guilford County Medical Society on November 4th. For the reasons (1) that you have sent a copy of these resolutions to other county medical societies with the hope that they may sustain the action of your society; (2) that the resolutions relate to the work of one of the branches of the State Government, and (3) that they deal with a problem of vast and vital concern to all our people, an open reply seems to be in order.

Your resolutions, after the customary preliminary friendly grip of their first section, proceed at once to attempt a decision with a knock-out for the State Board of Health in the next round, section two. There is no question about your getting the decision, about the Board's taking the count, if you can land with the full force of your all-inclusive swing! "We do not believe that the State Board of Health should institute a treatment campaign for any disease or condition." Your society evidently believes, with us, in that nugget of wisdom which Theodore Roosevelt voiced when he said: "It is unpardonable to hit lightly."

Your terrific swing catches the sanatorium like a tornado and leaves Montrose bare and barren. You repudiate all the State has done in the treatment of tuberculosis since 1907. No more treatment of any disease by the State, no longer treat the tuberculous in order that they may be cured and rendered harmless associates of their families and neighbors, for the treatment of *any* disease in order to prevent other cases is wrong in the judgment of the doctors of Guilford County.

It is a good thing that the hookworm campaign is about over in North Carolina and in the South, because if the Guilford doctors stop the State from treating a disease in order to prevent new cases all the work that reduced the prevalence of hookworm disease 35 per cent and that did away with all the aggravated types of the disease would have been impossible. The campaign against hookworm disease, as you will recall, was based upon *treating* the infected person in order to prevent that person from scattering the infection in such a way as to reach others.

Your knock-out, if it should land, would do more to cripple and to make ineffective the campaign against malaria, the one outstanding and the greatest of all Southern health problems, than anything that could conceivably happen, because one of the principal means for preventing malaria is the *treatment* of the chronic malarial carrier by quinine in order that his infection may be destroyed and not transferred by the mosquito to his family and neighbors. This method of malaria control, in many places, is the only available means by which the

disease may be prevented. It was well developed under the leadership of Gorgas in Panama and Cuba; it has been the main reliance in the control of the disease in the Roman Campagna; it is recommended by every textbook on preventive medicine; it is used by the United States Public Health Service and every Southern State Board of Health.

If your knock-out should land, the campaign against venereal diseases will be done away with. Your county society knows that during the war and on the battle front in France there were more soldiers in hospitals, physically incapacitated, from venereal diseases than from wounds received in battle; your society further knows that the government is responsible for the statement that these diseases are more prevalent among civilians than among soldiers. The strategy of the attack on venereal diseases was planned and adopted by these cabinet officers, assisted by the three surgeons general serving under them, to-wit, Secretary Daniels of the Navy, Secretary Baker of the Army, Secretary McAdoo of the Treasury, and Surgeon General Braisted of the Navy, Ireland of the Army, and Cumming of the Public Health Service. It consists in attacking the freshly infected person, cases of gonorrhea and syphilis in their easily curable stages, in *treating* the infected before he can convey his infection to others.

All of these instances are cited only as illustrations of the principle that in the prevention of many of our most important diseases prevention is based and conditioned upon treatment.

It would seem that the members of your county society had gone far enough when they expressed their opposition to the treatment of *any* disease by the State in order to prevent its being spread to others, but you were not satisfied. Your society believes in thoroughness. When its members move they go with such momentum, aided by gravity, that it is impossible to stop at the foot of the hill. They go right on into the sea. Not content with placing themselves on record against the treatment of *any disease* by the State, your society also record their opposition to the treatment of *any condition* by the State to prevent the development of disease, meaning, of course, the treatment by the State of the condition of susceptibility of persons to typhoid fever, smallpox, and diphtheria with vaccines and antitoxins in order to anticipate and prevent disease. The free vaccination by the officers of the State Board of Health of nearly 300,000 citizens of this State against typhoid fever within the last three years and the reduction of the total annual deaths from this disease from 839 in 1914 to 250 in 1920, due largely to typhoid vaccination, was a piece of work which, under the resolution of your society, should never have been done. And the resolution applies in the same way to vaccinations against smallpox and the use of antitoxins against diphtheria, which, by the way, in the last five years has had its death rate cut more than half in two.

The position assumed by your society in section 2, amazing as it is, is less amazing than the reason you advance for it. You say "the physicians of North Carolina * * * are fully qualified and in numbers sufficient to take care of the indigent sick, and none will or do suffer for want of medical attendance."

The purposeful use of the word "indigent" in the above quotation enables your society to avoid a collision with an immovable mass of facts regarding the prevalence of diseases. With that word you undertake to dodge the findings of the War and

Navy Departments, that 38 per cent of American men in the healthiest of all age periods, between 20 and 30, are physically defective, and a considerable per cent of these defectives are in need of medical treatment; you play on "indigent" to avoid the findings of the Life Extension Institute, showing that 59 per cent of industrial workers are in need of medical treatment, and only an insignificant fraction are receiving treatment; with "indigent" your society attempts to divorce the State's interest and care from 40,000 public school children in North Carolina suffering from defective adenoids and tonsils, from 600,000 school children needing dental treatment, from 15,000 persons suffering from tuberculosis, from 50,000 suffering from venereal diseases, from 100,000 suffering from chronic malaria, and from 30,000 mothers who go to childbirth each year in North Carolina, and that without any medical attention, assisted only by ignorant and, in many cases, illiterate midwives.

What does your county society mean by "indigent?" Can a democracy classify its citizens into indigent and non-indigent, paupers and able to pay? Does your society advocate it? If the State's concern for the health of its children should divide them into indigent and non-indigent, then why does your county society not advocate the application of the same principle to public education? Does human progress rest any more upon schools than it does upon health? Let me emphasize the point that your society seems to miss; namely this: the State is concerned not only for the health of those who cannot maintain health, your "indigent," but also and because of their larger number and their greater civic importance, is much more concerned for those that are not "indigent"; therefore, in providing for the vast numbers that suffer from various causes, the concern of the State is not whether or not they are "indigent," but whether they need treatment.

Coming now to sections 3 and 4 of your resolution, you give certain special reasons for your opposition to our treatment of public school children who suffer from diseased tonsils and adenoids.

Your first reason is that it "reflects upon the willingness of the physicians of the State to take care of these cases." The attitude of the profession, its willingness or unwillingness, has nothing to do with it. The fact that these children are not treated, and that fact alone, accounts for and necessitates the position of the State.

As for the second reason for your opposition to the treatment of these children by the State, namely, that the operations are unnecessary, expensive, and have been performed at places unsuited for any surgical procedure, call the witnesses. Here they are: Dr. C. N. Peeler, Charlotte; Dr. J. R. McCracken, Waynesville; Dr. M. R. Gibson, Raleigh; Dr. J. B. Wright, Raleigh; Dr. J. W. Austin, High Point; Dr. D. B. Sloan, Wilmington; Dr. J. G. Murphy, Wilmington; Dr. M. S. Martin, Mt. Airy; Dr. W. M. Scruggs, Rutherfordton; Dr. M. L. Matthews, Sanford; Dr. O. C. Daniels, Goldsboro; Dr. C. J. Ellen, Greenville; Dr. H. H. Briggs, Asheville; Dr. S. H. Lyle, Franklin; Dr. C. W. McPherson, Burlington; Dr. M. A. Royall, Elkin; Dr. W. E. Walker, Burlington; Dr. J. P. Parker, Burlington. Do you admit them as experts? Will you claim that there are any better specialists in your county society? Will you claim that you can bring together a like number of specialists in this State of better reputation and ability than these men? They did the operations, and at a cost of less than \$10 per child, but themselves received \$100 a day and all expenses for

their work. *The Journal of the American Medical Association* last spring stated that in operations on tonsils and adenoids the average fatality for the surgeons of this country was one death in 500 operations. In our club clinics there has been one death in practically 2,500 operations—a fatality of 20 per cent of the average.

As your society gave two reasons for opposing the tonsil and adenoid clinics, so we give two reasons for using them: (1) to prevent unnecessary disease and inefficiency, and (2) to promote school progress, not only for the diseased child but, more important, for the other children that would be held back in their classes if the defective were not treated.

Finally, as this letter is addressed not only to your society but to the public, it is necessary to emphasize the fact that your action does not represent, but misrepresents, the attitude of the State Medical Society to the general public health program of the State Board of Health. Especially is it important in this connection to point out the strong endorsement of the State Medical Society of the position of the Board in treating public school children with diseased tonsils and adenoids in the club clinics. Before we began this work in the public schools we submitted the plan to the State Medical Society, which approved it in detail. The Section on Eye, Ear, Nose, and Throat of the State Medical Society, when informed at their 1920 meeting that certain sporadic opposition to the club clinics for the treatment of adenoids and diseased tonsils in school children had manifested itself, unanimously adopted the following resolution: "Resolved, that the Eye, Ear, Nose, and Throat Section endorse most cordially the action of the Board of Health in reference to remedying defects in children." The Guilford County Medical Society is the only medical organization, national, state, or local, so far as we know, that enjoys the unenviable distinction that you have assumed in your recent resolutions.

Respectfully yours,

W. S. RANKIN,
State Health Officer.

[Comment.] THE JOURNAL appreciates the request of the State Health Officer to make editorial comment on the foregoing correspondence. But has Dr. Rankin in his reply left anything unsaid? He handled the situation without gloves and it is doubtful if the Guilford County Medical Society would sustain their action if the adoption of their resolutions could be brought before them for reconsideration. It must not be inferred that THE JOURNAL upholds in any sense "State medicine." The prevention of disease is the aim of a State Board of Health. Prophylaxis and treatment in so many instances run so close to each other that it is hard to know at times where one begins and the other ends. An individual infected with malaria comes into a community free of malaria, but with abundant non-infected anophelines present, treatment of that individual is a prophylactic

measure in the interests of every person in the community.

In carrying out such a program as Dr. Greene outlines in his communication, efficient organization, competent officials and adequate facilities should be the trinity to keep constantly in mind. That such would be the policy of the present State Health Officer is reflected in all acts of the Board during his administration.

The proposed reorganization of the State Board of Health is discussed elsewhere in this issue.

G. E. H.

PROPAGANDA FOR REFORM.

TANNIN COMPOUNDS USED AS INTESTINAL ASTRINGENTS.—On account of the irritant action of tannic acid on the stomach, a number of tannic acid compounds have been introduced which are assumed to pass the stomach practically unchanged but are broken up in the intestines with liberation of the tannic acid. Working in the A. M. A. Chemical Laboratory, P. N. Leech has made a study of the tannin compounds described in New and Nonofficial Remedies, and also of some recently introduced American products, to determine whether they are largely unchanged by action of gastric juice, and if so, whether they are capable of decomposition by the intestinal juice. For this purpose he determined the solubility of each compound in water and hydrochloric acid solution, acid and pepsin solution, and sodium bicarbonate and pancreatic extract solution. Only one type of tannic acid compounds studied completely resists the action of the gastric juice and is broken down in the intestine according to theory, *i. e.*, the diacetyl tannin acid compound acetannin. Tannigen is fairly satisfactory, but the market supply is not of reliable composition. Protan and tannoform are both readily soluble in sodium bicarbonate mediums, but they are probably not broken up to a great extent in the intestine. Of the tannin albuminates, Albutannin-Calco and Albutannin-M. C. W. are not

nearly so resistant to the acid-pepsin digestion as tannalbin and tannin albuminate exsiccated. Both tannalbin and tannin albuminate exsiccated (the latter now sold as Albutannin-Merck) are not particularly resistant to the acid-pepsin medium, but they do liberate free tannic acid in the alkaline-pancreatic medium. (*Jour. A. M. A.*, October 23, 1920, page 1120.)

CAPSULES FOLIA-DIGITALIS-UPSHER SMITH AND TINCTURE OF DIGITALIS-UPSHER SMITH.—The Council on Pharmacy and Chemistry reports that these preparations, advertised and sold by Upsher Smith, St. Paul, Minn., were considered and found to have the status of official articles. For this reason they were not admitted for inclusion in New and Nonofficial Remedies. (*Jour. A. M. A.*, Oct. 30, 1920, page 1205.)

SUPSALVS NOT ADMITTED TO N. N. R.—The Council on Pharmacy and Chemistry reports that Supsalvs are advertised by the Anglo-French Drug Co. as "stable suppositories of '606' (of French manufacture)" with the claim that by rectal administration of these suppositories the effects of arsphenamine may be obtained. The Council found Supsalvs inadmissible to New and Nonofficial Remedies, first, because the quality of the medicament contained in the suppositories has not been established and, second, because the claimed efficacy of this preparation as a means of securing the effects of arsphenamine lacks substantiating proof. In its report the Council quotes from L. W. Harrison on "The Treatment Of Syphilis," from Schamberg and Hirschler on "A Safe And Efficient Intensive Method of Treating Syphilis," and from the report of the special committee on the manufacture, biological history and clinical administration of salvarsan and other substances of The British National Insurance Medical Health Research Committee, to show that the general opinion of experienced workers is to the effect that the rectal method of administering arsphenamine is ineffective. (*Jour. A. M. A.*, Oct. 30, 1920, page 1219.)

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Next Meeting—Pensacola—May, 1921

THE A. M. A. INCREASES ANNUAL DUES.

At a special meeting of the House of Delegates of the American Medical Association, by a practically unanimous vote, the annual Fellowship dues were increased to \$6. The necessity for the increase in Fellowship dues was ably presented by Dr. George H. Simmons, editor of the *Journal of the American Medical Association*, and Dr. Frank Billings, chairman of the Board of Trustees.

There was practically no opposition to the proposed increase, the delegates plainly seeing the necessity. It is believed that the American medical profession will at all times be willing to pay for value received, and that under the present regime no one would dispute that the American Medical Association is giving full returns for all moneys received. It is believed that there is not in existence at the present time, or during any time in the past, a medical organization as active in the interests of the medical profession as the American Medical Association. Nor are its activities confined to the betterment of the medical profession alone, for surely the works of the Council on Pharmacy and Chemistry, the Council on Health and Public Instruction, and the Council on Medical Education and Hospitals are far-reaching in their efforts and of inestimable benefit to all mankind.

In its issue of November 20th the *Journal of the A. M. A.* has the following to say concerning the increase in annual dues:

"Elsewhere in this issue appears the report of a special meeting of the House of Delegates of the American Medical Association called to act on a proposition submitted by the Board of Trustees to increase the annual Fellowship dues. The House of Delegates modified the by-laws, increasing these dues from \$5.00 to \$6.00, the new arrangement to be effective for 1921. As explained in the minutes of the meeting of the House of Delegates, this increase is made necessary by the greatly increased cost of material and labor in the printing trade. Considering

merely the amount of material contained in *The Journal* each week, even at the new rate *The Journal* is lower in price by far than any other scientific periodical, medical or otherwise, in the world. The increase is 20 per cent—very small as compared with the increase in the subscription prices of other periodicals, especially those published by scientific organizations. The British Medical Association recently has increased its annual dues, which means subscription to the *British Medical Journal*, from \$10.50 to \$15.75. It may be well to recall that the income from *The Journal* supports the Association's activities in the interest of the medical profession and the public: for instance, the work of the Council on Pharmacy and Chemistry, of the Chemical Laboratory, of the Council on Medical Education and Hospitals, of the Council on Health and Public Instruction, and of the Biographical and Propaganda departments. Thus, when a physician pays \$6.00 he is not only paying for *The Journal*, but also for the above enumerated enterprises and other activities in behalf of the medical profession and the public." G. E. H.

PROPOSED PLANS FOR THE RE- ORGANIZATION OF THE STATE BOARD OF HEALTH.

The medical profession of the State recently received a communication from Dr. Ralph N. Greene, State Health Officer, in which he suggested certain reorganization plans for the State Board of Health. *THE JOURNAL* has been asked by the State Health Officer to comment editorially on his letter to the profession. The matter will, therefore, be discussed in the abstract, dealing with generalities as applied to Public Health Work. The first and foremost policy the political body of a State should consider in establishing a public health organization is efficiency. If efficient health officers are to be obtained, the remuneration should be sufficient to attract medical men to public health work.

The proposal to employ all-time county health officers will result in untold benefit to the State if each and every officer so employed be efficient. The Governor-elect of a nearby State is credited with having stated in effect that in every county in his State could be found at least one physician with an income amounting to ten thousand dollars per annum—derived from treating the sick; that it was his intention to place an all-time health officer in each county on an equal financial status just as rapidly as possible, maintaining, and properly so, that if the services of a physician treating the sick were worth ten thousand dollars a year, the services of another employed for the purpose of keeping people from becoming sick, were of equal value.

The slogan of State public health organizations should be "No politics." Taking our own State as an illustration: The present State Health Officer has announced his intention of retiring from office. The selection of his successor will be made by the State Board of Health, this Board being appointed by the Governor for a term of four years. Is it reasonable to assume that any man wishing to make public health his life work would care to enter a field with the full knowledge that just about the time he had perfected an organization, a Board unfavorable to him can remove him from office? So with the county health officer; can efficient men be induced to accept service, knowing that their tenure of office in all probability depends upon their political complexion? We would like to see enacted a law providing that the State Board of Health consist of five members, the Florida Medical Association and the Florida State Bar Association each submitting a stated number of nominations to the Governor of the State, it being understood that these nominations need not necessarily be selected from the membership of the organizations mentioned. From these nominations the law would provide that the Chief Executive be required to select three from the nominations made by the Florida Medical Association and two from the nomina-

tions made by the Florida State Bar Association, the whole constituting the State Board of Health.

The State Board of Health, as constituted above, should have the power of electing a State Health Officer for a term of at least six years, proper remuneration being provided for.

In some similar way the County Health Officers should be selected by the County Boards of Health, the Boards being governed in their choice largely through the advice or recommendations from non-political organizations, always including the county medical society where one exists.

Laboratories should be maintained at practical points, where they serve the greatest public need. The work conducted in these laboratories should be under the supervision of a Director General and should cover all laboratory methods necessary to carry on public health work.

The Bureau of Child Welfare — than which there is no more important work — should be directed by an Assistant State Health Officer, the Bureau of Vital Statistics should be in charge of an efficient Vital Statistician. Venereal disease control and treatment should have a competent head, and all employees, understanding full well that their tenure of employment depended on efficiency and efficiency alone, should receive adequate and proper compensation.

There has been no attempt to map out the line of activities of a State Board of Health — they will naturally vary with the State and the particular sections of that State, but with a State Health Officer chosen in a non-political manner, with that officer having full knowledge that his tenure of office is dependent upon efficient public health activities, the people need have no fear but that every dollar expended in public health activities will earn handsome dividends in the form of better health for the individual, the community and the State at large. G. E. H.

NEW AND NONOFFICIAL REMEDIES.

CORPUS LUTEUM TABLETS-ARMOUR 5 GRAIN. — Each tablet contains 5 grains of desiccated corpus luteum-Armour (see New and Nonofficial Remedies, 1920, p. 203). (*Jour. A. M. A.*, Sept. 18, 1920, p. 815.)

SODIUM DIARSENOL.—A brand of sodium arsphenamine. Sodium diarsenol is marketed in ampules containing 0.15 gm., 0.3 gm., 0.45 gm., 0.6 gm., 0.75 gm., and 0.9 gm., respectively. Diarsenol Laboratories, Inc., Buffalo, N. Y.

OVARIAN RESIDUE-H. W. D.—The residue from the fresh ovary of the hog, after the ablation of the corpus luteum. Ovarian Residue is used for the same conditions as the entire ovarian substance, but is claimed to have the advantage of being somewhat more stable. Ovarian Residue-H. W. D. is supplied in the form of 5-grain tablets only. Hynson, Wescott & Dunning, Baltimore. (*Jour. A. M. A.*, August 7, 1920, p. 378.)

BENZYL BENZOATE-SEYDEL.—A brand of benzyl benzoate complying with the tests and standards of New and Nonofficial Remedies. For a discussion of the actions, uses and dosage of benzyl benzoate, see New and Nonofficial Remedies, 1920, p. 48. Seydel Manufacturing Company, Jersey City, N. J.

TABLETS ANTERIOR PITUITARY-ARMOUR, 5 GRAINS.—Each tablet contains 5 grains of desiccated Pituitary Substance- (anterior lobe) Armour (see New and Nonofficial Remedies, 1920, p. 207). Armour & Co., Chicago.

TABLETS OVARIAN SUBSTANCE-ARMOUR, 5 GRAINS.—Each tablet contains 5 grains of Ovarian Substance-Armour (see New and Nonofficial Remedies, 1920, p. 202). Armour & Co., Chicago.

RIODINE.—A 66-per cent solution in oil of an iodine addition (see Iodine Compounds for Internal Use, New and Nonofficial Remedies, 1920, p. 143. Riodine is supplied only in the form of Riodine Capsules 0.2 gm. E. Foughera & Co., Inc., New York. (*Jour. A. M. A.*, August 14, 1920, p. 477.)

AMPOULES VEN-IRON CACODYLATE.—Each ampule contains 0.03 gm. ($\frac{1}{2}$ grain) of ferric cacodylate (see New and Nonofficial Remedies, 1920, p. 44) in physiological solution of sodium chloride. Intra Products Co., Denver, Colo. (*Jour. A. M. A.*, July 3, 1920, p. 35.)

SODIUM ARSPHENAMINE. — SODIUM ARSENPHENOLAMINE. The sodium salt of 3-diamino-4-dihydroxy-1-arsenobenzene with

advantage over arspenamine is that it does a stabilizing medium. The arsenic content of three parts of sodium arspenamine is equivalent to two parts of arspenamine. Sodium arspenamine has the same actions and uses as those of arspenamine; its not require addition of alkali before use. To prepare the solution the sodium arspenamine is added to the required amount of sterile water and dissolved by gentle agitation.

PUBLISHER'S NOTES

BENZYL BENZOATE.

According to reports, the medicinal ester chemically known as Benzyl Benzoate continues to give results and to justify the recommendations made at the outset by Macht and others. Especially is it effective in the treatment of painful menstruation, provided this be caused by spasm of the uterine musculature. Clinicians are quite in agreement as to that. Litzenberg, for one, says that he found it satisfactory in 81 per cent of the cases treated.

Macht, himself, suggesting further uses for the drug, has recently attested its efficacy in whooping-cough. It does appear to reduce very decidedly the number of paroxysms as well as their severity. Those who have not yet tried it in this disorder should not fail to do so. Hiccough common in infants is another indication for its use.

The Abbott Laboratories supply Benzyl Benzoate in two forms, tablet and elixir, both of which are truly representative of the drug.

BACTERIAL VACCINES (SHERMAN'S).

The organisms in Sherman's Vaccines are grown on ascitis agar which makes them more nearly conform to the bio-chemical

construction of organisms responsible for human infections. They are the only vaccines produced on a large scale that are sterilized without heat. This avoids the possibility of destroying the delicate bacterial protein which is so liable to follow from the heat killed method of sterilization. This results in the production of a vaccine high in antigenic and keeping qualities. All vaccine suspensions are carefully counted and standardized so that a change can be made from one package of vaccine to another of the same kind with the same therapeutic response.

Dose: For the heavier suspensions such as Nos. 6, 22, 25, 35, 36, 38, 40, 42, 43 and 49, the first dose is 0.2 (c. c.) or about 3 minims; in chronic cases this dose is repeated at intervals from three to seven days. In extensive acute infections with high fever the dosage may be 1 mil. given every day until the temperature subsides and then at longer intervals.

Infants and children who are very tolerant to Bacterial Vaccines should receive $\frac{1}{4}$ to $\frac{1}{2}$ the adult dose.

"Largest producers of stock and auto-genous vaccines"—Laboratory of G. H. Sherman, M. D.

PALATABLE 20% BENZYL BENZOATE (VAN DYKE & CO.)

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You Need Vitamines!

Medical Science has decided that the human system needs vitamins. If they are not supplied, the powers of resistance will slip away. Naturally, the run-down condition which is the first symptom of the lack of vitamins appears when proper foods are not taken. However, a run-down condition is really only a warning of other ills caused by lack of vitamins.

Without vitamins people cannot keep well. They cause food assimilation and consequent growth in children—in grown-ups—by a like stimulation of the food assimilating powers. They replace worn tissue and lost bodily vigor. In short, they are essential to life itself.

New knowledge about food and nutrition has revealed heretofore unknown causes of disease traced to wrong food or a diet containing insufficient vitamins, the heretofore little-known things occurring in some foods and absent in others.

The Medical press are constantly airing the question: "Do self-rising flour mixtures destroy the original vitamins in flour either through bleaching or as a result of the mixtures, the nature of which requires the acid and alkali ingredients to lie in continual contact with the flour itself?" If, as many claim, this question is to be answered in the affirmative, it naturally follows that bread, biscuits, and pastry made from self-rising flour lose considerable of the vitamins; therefore, the system does not receive the full value of the food taken. The safe course which is pointed out to the family physician is to recommend pure, plain flour and a baking powder of standard quality, like Calumet, and to be especially watchful in all cases of malnutrition to avoid a diet without vitamins.

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ORIGINAL ARTICLES

MEDICAL JOURNALS AND THE CAMPAIGN AGAINST CANCER.*

FRANK J. OSBORNE,

Executive Secretary, The American Society for the Control of Cancer.

Rather a large order and one which should be neither adulterated nor shortweighted. The campaign against cancer is all that the name implies. It has been, and for years to come will be, a battle. A fight against gross ignorance and traditional fear and hopelessness on the part of the lay public and no small skirmish against a degree of lethargy existing even in the medical profession. However, we have been told that battles are lost in the same spirit in which they are won by real fighters, and we must therefore maintain a hopeful and aggressive spirit in our efforts to overcome this, one of the most difficult of all medical problems, if we hope to make any eventual headway against it. It is true that our present-day methods of treatment hold out very little hope in advanced or late cases of cancer; but it is equally true that recognition of early symptoms and immediate competent treatment justifies a most sanguine attitude and really gives hope of ultimate successful treatment of the majority of cancerous and precancerous conditions. This is the message which the American Society for the Control of Cancer has attempted to propagate during the six years it has been in existence, and those who have been in a position to observe and who have kept careful records of progress claim that results are now beginning to manifest themselves; some stating that as high as 80 per cent of successful cures could be obtained in certain areas,

if the patients would but present themselves for treatment early.

Having its birth as this society did, within the medical profession in response to a resolution adopted by the American Gynecological Society and endorsed by the Congress of American Physicians and Surgeons in 1913, it has enjoyed the closest cooperation from the organized medical fraternity and its official journals. From the very first it was recognized that the medical publications of the country constituted one of the most powerful agents for the dissemination of cancer control information to the profession, and it is a pleasure to be able to say that this cooperation has continued and advanced during the past years. Hardly a month goes by that some cancer paper or editorial does not appear in these journals, and it is worthy of note that even though the paper itself may make no mention of the national campaign being waged against this disease, the discussion which follows almost invariably brings it out and stresses the point that eventual success lies in impressing upon the public the necessity of prompt and intelligent action and upon the profession the necessity of equipping itself to render effective service in the way of diagnosis and treatment when the patient presents himself for advice. The latest evidence of cooperation between your journals and this society was the way in which you made known to your readers the existence of the new handbook prepared especially for the medical profession setting forth the latest and most approved methods of handling this disease. The announcement which went forth in your columns resulted in innumerable requests for this booklet and has been a source of encouragement to the society and a full recompense for the time and energy devoted to its preparation.

*Read before the Fifty-first Annual Meeting of the American Medical Editors' Association at New Orleans, April 27, 1920.

I should now like to be a little more explicit and attempt to indicate, with your indulgence, certain ways in which medical journals can greatly increase this valuable cooperation and be even more useful as a medium of suggestion and education to the medical profession and through it to the general public. The policy of the society has been, to have State Medical Societies appoint permanent cancer committees. During this six-year period twenty-one such societies have done so. Many of these committees, however, flourished for only a short time after their formation and have now with a few notable exceptions either become inactive or have ceased to exist. In urging the appointment of these committees the society has always stressed *permanency in office* because of the fact that cancer is a disease which is constantly present in the population and one against which only continued efforts of education can make any impress. It is, therefore, felt that such committees should be composed of a few carefully selected men upon whom should be placed the duty of organizing and carrying out a thorough-going and persistent system of attack which could not be so well done if the personnel of these committees was constantly changing. Having gone this far, however, the society is, by the very nature of the case, compelled to stop. These special cancer committees appointed in most cases merely at the suggestion of the society, are not of it, and not subject to outside dictation or even suggestion. But it is self-evident that the editors of medical journals are in a position to greatly assist both this society and these committees. The readers of these journals always read with interest and due respect suggestions coming from the editorial desk. Such recommendations as might be editorially offered would certainly receive far more consideration, coming officially, than if they came from an organization such as the Cancer Society which at best would be nonofficial. Medical editors, by taking an active interest in the organization of such cancer committees, could largely shape the make-up of such

bodies. It would be simple to show why such committees should be permanent as to tenure and composed of men carefully selected for their prominence, interest, energy and sanity. The appointment of such cancer committees is a matter of no small moment, and if the efforts of the members are to result in anything worth while in the cancer control campaign they should be most judiciously chosen. The whole success of such a movement often depends upon the character of the appointees on such committees.

Having shown your subscribers the way to organize such committees, may I invite you to go one step further? It is a well-known fact, and one which simple observation in almost any direction will verify, that many committees, even though well chosen and organized, drop off into a state of coma or actually die of inanition. As a rule such committeemen to be really useful are busy men. They cannot be expected to devote a great deal of their valuable time to work even of this highly humanitarian nature. Medical editors might well consider themselves in the nature of executive secretaries. One of their normal functions is to stick pins into slumbers and to make first suggestions. It is often easier for any committee or organization to work a plan than to plan work. By virtue of his office the medical editor is in the best possible strategic position to sustain interest and get action. He is in the vanguard of the medical movement. He is in possession of all tried and proved methods of the public health and preventive medicine campaign. It is not new for him to outline programs of activities and, with the added facility of presenting such programs in an appealing and forceful manner, results would be found to follow. In this way he would take the burden of this fundamental work off the shoulders of the committee, which would result not only in conserving their time and energy but in giving them the latest available information as to how to prosecute this particular educational campaign. It is realized that some committees are so blessed with specialized talent or lead by a chairman so

well equipped with organizing and campaigning ability that such service from medical editors would not be required. On the other hand it has been our experience that no matter how efficient and successful a committee may be, there will come a time when its activities will lag and its effectiveness begin to wane unless stimulated from some outside but closely cooperating and helpful agency.

While not assuming to have perfected any such program of activities for use by medical editors, it might not be amiss at this time to suggest a few of the more obvious lines of attack in order to block out roughly the scope of work with which such a committee might properly interest itself. Its first attention should of course be directed to the official medical organizations in its state, and in view of the fact that education of the profession should go hand in hand with that of the public, we would place equal emphasis upon both phases of the subject. In order to indicate how this end may be attained, I would call attention to two activities recently carried out by cancer committees of state medical societies. In Massachusetts, by cooperating with the State Department of Health, the Medical Society secured the distribution of the new handbook for the profession entitled, "What We Know About Cancer." This is a most fundamental piece of professional education. The booklet is brief, readable, authoritative and suggestive. To have placed it in the hands of each medical man in this state is a distinct service and one which is most heartily appreciated by the Cancer Control Society, and will no doubt go far in our educational campaign. As a parallel to this educational work in the profession the Cancer Committee of the Ohio State Medical Association has just conducted a "Cancer Week" throughout that state. As a preliminary to this campaign a series of meetings was held among county medical societies and academies of medicine on the subject of cancer. The state was then divided into eleven districts, each with a supervisor to manage the details of the campaign. A

large number of qualified medical men were appointed as lecturers to address lay audiences and two hundred and fifty of the lecture outline prepared by the National Society were provided in order that these lecturers might present the subject in a uniform manner. The "week" was started with a "Cancer Sunday," on which the subject was briefly presented from the pulpits in the various churches, and during the ensuing seven days the speakers addressed groups of women's clubs, welfare organizations, chambers of commerce, rotary clubs, and others. These are concrete instances indicating how well such cancer committees can function when properly guided. The chairmen of these two committees are to be congratulated for their efficiency, and it is hoped that they will continue the work so well begun. Another useful suggestion would be that each local medical organization, whether a county society or academy of medicine, be urged to devote at least one meeting each year for its own members to a discussion of cancer and hold at least one public meeting on the same subject annually.

Somewhat removed from the medical organization group but still intimately connected with it are hospitals and dispensaries, and nursing organizations and training schools. Posters and placards on cancer should be prepared for bulletin-board display in these institutions and every effort should be made through medical staffs or hospital superintendents to include cancer control in the lecture course for pupil nurses. All such schools should be supplied with special literature prepared for nurses, and nurses' associations, both state and local, should be encouraged to provide speakers on the subject at their various meetings. Red Cross and all Public Health nurses as well as industrial nurses should be supplied with the same information through lectures and pamphlets.

Another suggestion which medical editors might bring to the attention of chairmen of cancer committees is to interest the members in bringing the latest supplementary cancer-control information to students in medical

schools and colleges. Special stress should be laid upon giving due attention to instruction of students in the recognition of precancerous conditions. Our present-day knowledge indicates that the best hope of preventing cancer is to inform the public of the predisposing danger signals and to educate the profession to recognize them as such. If it be true that our best hope of controlling this disease lies in acquainting the younger generation with these facts, it is equally true that complete success implies that no medical man should enter upon the practice of his profession without a thorough knowledge of all diagnostic procedures.

Three other agencies whose major interest is strictly professional are public health associations, health centers, and industrial physicians and surgeons. All these groups are doing most valuable preventive medicine work. Each is brought in intimate contact with numberless people who require instruction, and no cancer committee can do a thorough job of professional education on the subject of cancer without enlisting the cooperation of these groups.

After having completed this part of the program which has to do specially with work through professional or quasi-professional bodies (or rather while keeping step with this part of the program as was done in Ohio), the committee should include in its activities further educational work with groups of lay or non-professional organizations. A suggestive campaign of this nature has just been completed by the Colorado State Committee for the Control of Cancer. During the last few weeks of 1919 the committee's lecturers delivered twenty-two talks on the subject of cancer control which were heard by about 4,000 individuals. Aside from one before the State Medical Society and another to hospital nurses, the following audiences were addressed which shows the diversity of the public reached: The State Federation of women's clubs, employees of five department stores, employees of three industrial concerns (one a group of 1,300 miners), the State Educational Association, State

Librarians' Association, and State Congress of Social Workers; a Ladies' Aid Society, one church congregation, and a Parents' Association in a high school. This indicates the types of audiences which may be addressed to advantage upon this subject, and when we add to them chambers of commerce, manufacturers and merchants' associations, trades councils and unions, ministerial and other clerical groups, fraternal orders, Y. M. and Y. W. C. A.'s, civic and study clubs, all of which have been used from time to time as medium through which to disseminate the hopeful message of cancer control, we begin to grasp something of the immensity of the work before us and to appreciate that the word "campaign" is most aptly chosen.

I have left for the last the consideration of one of the most important if not the most important and useful of all cooperating agencies through which such a cancer committee can operate. I refer to the public health departments, state and local. Having been a health officer myself, I am cognizant of the misunderstandings which sometimes exist between the organized profession and these official departments. This is not the place or the time to even sketch the underlying causes of this unfortunate situation. It is enough at this time to state that in the fight against cancer the state medical societies and state and local boards of health should work together as a unit. With the prestige and funds which well-organized and well-supported health departments can command, no chance for cooperating with them should be lost. Through their regular publications, exhibit and lecture bureaus as well as through their nursing staffs, demonstration clinics, health centers, etc., a unique opportunity is offered for the most effective kind of team work. It is not difficult to show to boards of health the desirability of such cooperation when the possibility of cutting down the death rate from this disease through intensive educational methods is properly presented.

One last word, and that one in which I am sure the editors of medical journals will en-

tirely concur. In making suggestions for carrying out a program of activities, particular stress should be laid upon the desirability of free use of printer's ink. After all it is the general public that the majority of meetings are designed to reach. Success in the control of this disease can be said to be in direct proportion to the number of persons who have been persuaded by the dissemination of information to give immediate attention to suspicious symptoms. The medical man is the one who must prepare and deliver the facts, for only he has them. He should then be assured the widest possible hearing and his audience can be increased manyfold by a well-organized and smooth-working press bureau which will see that his address is digested and reprinted in the public press. Where one hears the lecture hundreds read the papers. If the information is valuable for people to hear it is equally valuable for others to read. A sub-committee on publicity is, therefore, most essential.

I will now leave this matter for your consideration, feeling sure from the experience of the society in the past that this additional assistance on the part of medical editors will strengthen the bond of cooperation existing between your association and that which I represent. As an example, I may cite the splendid results of propaganda publications prepared and distributed for popular use by the American Medical Association, some of them in cooperation with our society. I appreciate that for medical editors to take up this work means a new line of endeavor, and I recognize the difficulty of taking the first step in a new venture. However, I can assure you that if entered into with the spirit which the importance of the service merits there is no one thing which medical journals could undertake which would so far advance the campaign for the control of this disease. You may feel sure that the American Society for the Control of Cancer is most anxious to assist in any way in which it may be privileged to do so.

DIFFICULTIES IN DIAGNOSING ACUTE APPENDICITIS.*

JOHN S. McEWAN, M. D.,

Attending Surgeon to Orange General Hospital,

Orlando, Florida.

My teacher, that Master Surgeon, the late Dr. John B. Murphy, used to impress upon us the four cardinal symptoms of appendicitis: Pain, nausea and vomiting, elevation of temperature and local sensitiveness, and that they usually appeared in the order named.

But oftimes the diagnosis is a matter of much perplexity, especially for the internists, and I believe many of us need to revise our notions of the symptomology. We have the habit of looking for certain signs and symptoms supposed to be typical, like sudden pain in the right lower quadrant, tenderness, tension, nausea, fever and leucocytosis.

But appendicitis is as atypical as typhoid fever. The symptoms vary, often some are absent, and they may be mixed in the most erratic manner—pain may be almost absent in the appendix and amount to agony in the epigastrium; the appendix may be in the wrong place; there may be little tenderness in the appendix itself; there may be only a trifle of fever, and no abdominal muscular tension whatever.

With the brief time allowed me for this paper, I think the best way to present it to you will be to cite a number of cases which have lately come under my observation.

CASE 1. Referred by Doctor A. Diagnosis: Acute appendicitis. Woman, 26 years, married, six months pregnant.

History: Three days previously had sudden attack of severe pain in the right side over appendix, pain radiating toward kidney and also toward pelvis. This was followed by slight chilliness and tenderness (acute) over McBurney's point, with fever. Pain so severe, doctor administered a hypodermic. The pain, tenderness, and fever persisting, she was sent to the hospital for operation.

*Read before the Florida Midland Medical Society, at Orlando, October 13, 1920.

Examination: Temperature 103, pulse 120, respiration 30, pregnant six months, exquisite tenderness over appendix and some tenderness over entire right side. Leucocytosis 14,500.

Urine Examination: Small amount of pus, pain in passing urine, but not severe.

History, pain (constant in one place), tenderness, fever and leucocytosis, appendicitis.

Operation: Appendix normal. The following day a large amount of pus appeared in the urine.

Diagnosis: Acute pyelitis. After two weeks of treatment, patient recovered.

CASE 2. Referred by Doctor B. Woman, 21 years, married.

History: Six weeks previously had given birth to baby, normal delivery, normal convalescence. About three weeks after baby was born, began to have slight pain in right side (no nausea or vomiting), fever, and a tenderness in the right lower quadrant. This had continued for three weeks.

Diagnosis: Appendicitis.

Examination: Temperature 100, pulse 110, respiration 20. Tenderness over and below McBurney's point, and extending upward. No rigidity.

Vaginal Examination: Profuse leucorrhea, tenderness and enlargement of both tubes.

Urine: Full of pus.

Blood: Leucocytosis 12,000.

Diagnosis: Acute salpingitis with possible pyelitis.

Operation: Double pyosalpinx and sub-acute appendix.

CASE 3. Woman, 18 years, single. Was walking to garage to get car when acute pain struck her in the right side so fearful that it doubled her up and she was carried to the house screaming with pain and vomiting. Her family tried to relieve her, but failed and called me. When I arrived about an hour after the attack began, the pain had left her suddenly and she was comfortable.

Examination: Menses normal, temperature 98.6, pulse 110, respiration 18. No pain. Tenderness over both lower quadrants, more especially over appendix. No temperature. Did not make a vaginal examination. She looked sick. Suspected appendicitis, and advised operation immediately, and in an hour, had her abdomen opened. No appendicitis, but ruptured hemorrhagic ovary with profuse hemorrhage. Abdominal cavity full of blood. No urine or blood examination was made.

CASE 4. Consultation after operation for acute appendix. Woman, 19 years, single.

History: Indefinite pains in right side for about a week with tenderness over lower right side and varying fever, and feeling worse every other day. Doctor made diagnosis, acute salpingitis, without making vaginal examination and called another physician in consultation. He making one of appendicitis, she was opened but nothing found. No urine or blood examination being made. I saw her three days after the operation, with temperature and still feeling bad. An examination of her blood disclosed a *malaria*. Quinine cured her appendix and pus tubes.

CASE 5. Referred by Doctor D.

Diagnosis: Acute appendix with probable peritonitis.

History: An indefinite history of pains in right side for past four days, very severe at times, then no pain. Nausea when pains were severe, some irregularity with menses for some months.

Examination: Temperature 99.6, pulse 130, respiration 26. Rather anemic woman who looked sick. Tenderness over entire lower abdomen, no rigidity, acute pain had entirely disappeared.

Vaginal Examination: Tenderness in entire vault of vagina. Leucocyte count 6,500, differential, no increase in polymorphonuclears.

Urine: Negative.

Diagnosis: Either ruptured appendix with beginning general peritonitis or ectopic, ruptured.

Operation: Ruptured hemorrhagic cyst of right ovary.

CASE 6. Referred by Doctor E. Woman, 38 years, married.

History: Sixteen years ago had hysterectomy and at same time appendix was removed. Eight years ago had an attack of acute pain over the appendix followed by nausea and tenderness, but no elevation of temperature. During the attack she passed a little blood in her urine. She has had numerous attacks since, had number of physicians who said her appendix had not been removed.

Urine: Blood and pus, tenderness over region of appendix, percussion painful over right kidney.

X-Ray: Stone in right kidney.

Diagnosis: Stone in right kidney.

Operation: Removed.

I cite the above cases to show the mistakes we can make in the diagnosis of acute appendicitis and to emphasize the importance of making routine laboratory examination in all cases: blood, urine, X-ray, etc.

We must remember that while the early symptoms indicate clearly the nature of the trouble to begin with, the later symptoms often fail to indicate the malignant course which the pathologic process is pursuing. Therefore, operate, and operate at once. Do you know that the combined statistics of several hospitals show a mortality of 10 per cent in operations for appendicitis? Do you know that 98 per cent of all acute appendicitis, including those with abscesses and peritonitis, that are operated within the first twenty-four hours are saved? Why have those 10 per cent been lost? Procrastination was the cause of death. *Waiting*. Operate, and operate at once.

PROPAGANDA FOR REFORM.

A SHOTGUN MIXTURE.—It is stated that the following prescription is used with success in "intestinal cases of a medical type": zinc sulphocarbolate, 0.5; bismuth subnitrate, 15.0; bismuth betanaphtholate, 8.0; camphorated tincture of opium, 15.0; syrup of acacia, 30.0; elixir lactopeptine, to make

130.0. In this, the chief active ingredients are bismuth subnitrate and camphorated tincture of opium. The zinc sulphocarbolate is superfluous. The action of the bismuth betanaphtholate probably does not differ from that of bismuth subnitrate, and cinnamon water or simple elixir might as well be substituted for elixir lactopeptine. (*Jour. A. M. A.*, July 31, 1920, p. 335.)

NA VS. K.—Advantages of sodium over potassium salts: (1) *Rational therapeutics*. Sodium compounds are as efficient as, in many instances better than, the corresponding potassium compounds. Potassium is more toxic. (2) *National aid*. Accustom yourself to use sodium, an abundant natural product of the United States. The home of potassium is Germany, which, to its own commercial gain, popularized potassium drugs. (3) *Price*. Sodium salts are cheaper. Potassium is, relatively speaking, a foreign substance in the body. Potassium and sodium salts are prescribed mainly for the effects of the radicle they carry. It is illogical, therefore, to administer potassium acetate or potassium bromid when sodium acetate or sodium bromid can more readily be given. In spite of the smaller demand, sodium salts are, on the whole, cheaper than potassium salts and, should the medical profession prescribe the sodium more generally, all of those that might be used in medicine would be less expensive than the corresponding potassium salt. (*Jour. A. M. A.*, July 17, 1920, p. 192.)

ALKALITHIA. — Keasbey and Mattison Company's Effervescent Alkalithia was introduced at a time when it was believed that the administration of lithium salts served to remove uric acid from the system. The A. M. A. Chemical Laboratory reported that Alkalithia is an effervescent mixture which contains alkaline carbonates and bicarbonates together with caffein, free tartaric acid and free citric acid and that, as taken, it represents caffein in solution of alkali tartrate, citrate and bicarbonate containing free carbonic acid. The Council on Pharmacy and Chemistry declared Alkalithia inadmissible

to New and Nonofficial Remedies because the claims made on the label and in the circular accompanying the trade package led the public, to its detriment, to depend on this preparation and because the therapeutic claims are unwarranted. (Reports Council Pharmacy and Chemistry, 1919, p. 65.)

MORE MISBRANDED DRUG PRODUCTS AND NOSTRUMS.—The following products have been the subject of prosecution by the federal authorities under the Food and Drugs Act: Seelye's Wasa-Tusa, Dr. Seelye's Compound Extract of Sarsaparilla, Seelye's Laxa-Tena, Seelye's Cough and La Grippe Remedy and Seelye's Fluorilla Compound (A. B. Seelye Medical Company) were misbranded because the therapeutic claims were unwarranted. Aspirin Tablets (Verandah Chemical Company) were misbranded because they contained no acetylsalicylic acid (aspirin). Dr. Grove's Anodyne for Infants (Smith, Klein & French Company) was misbranded because the therapeutic claims were unwarranted and because the carton failed to contain a statement of the quantity and proportion of morphine and alcohol contained therein. Cacapon Healing Water (Capon Springs Company) was adulterated in that it consisted in part of a filthy, decomposed and putrid animal and vegetable substance and misbranded because the curative claims were unwarranted. Seawright Water (Seawright Magnesian Lithia Spring Company) was adulterated in that it consisted in part of a filthy and decomposed vegetable substance. (*Jour. A. M. A.*, July 24, 1920, p. 261.)

BORACETINE.—Boracetine (F. E. Barr & Co., Chicago) in 1919 was heralded as "The Guardian of Health." It was claimed to be "an all-around antiseptic, especially good for pyhorrea, sore gums, sore throat, etc., excellent for cuts, bruises, insect bites, skin eruptions and, in fact, any condition when an efficient healing agent and germ destroyer is needed." It was also recommended to "get rid of that 'dark brown taste'." Indirectly, Boracetine was also claimed to be a preven-

tive of consumption, scarlet fever, diphtheria, etc. From the analysis made in the A. M. A. Chemical Laboratory it appears that Boracetine is nothing more wonderful than *Liquor Antisepticus, N. F.*, with a dash of formaldehyd. The more "patent medicines" are analyzed the more obvious becomes the commercial wisdom of the nostrum interests to fighting formula disclosure. Secrecy and mystery are the "backbone" of the "patent medicine" industry. (*Jour. A. M. A.*, July 17, 1920, p. 192.)

FAKE ORANGE BEVERAGES.—The orange and other citrus fruits possess value other than that which can be measured by flavor or fuel value. They are relied on as anti-scorbutic by a large number of persons in the preparation of food mixtures which for some reason are deficient in this protective element. Oranges merit additional favor because they are relatively rich in the water-soluble vitamin B, sometimes designated antineuritic vitamin, which promotes well-being in as yet an undetermined way. In view of these facts, the chemists of the U. S. Public Health Service have done well in their timely warning against the "fake" orange beverages that have come to their attention. They report that in most cases the fraudulent products consisted of carbonated water, flavored with a little oil from the peel of the orange and artificially colored to imitate orange juice. (*Jour. A. M. A.*, Oct. 16, 1920, page 1073.)

VACCINES IN TOXIC CONDITIONS.—Under this title an article purporting to be a scientific contribution appears in the original department of the *Illinois Medical Journal*. The apparent purpose of the article is to overcome any hesitancy on the part of practitioners to use vaccines in toxic infectious conditions for fear that they might thereby cause harm. The theory propounded is contrary to those who have studied the subject. The man who writes the article, G. H. Sherman, is in the business of making and selling vaccines, though this is not made evident in the article. (*Jour. A. M. A.*, Oct. 23, 1920, page 1140.)

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ANNUAL DUES.

Blank forms upon which to make their annual report to the State Association have been mailed to the various County Secretaries throughout the State. The letter of transmittal calls the attention of the Secretaries to the action of the House of Delegates at the Daytona meeting in raising the dues to five dollars. It is recognized that this increase of dues comes just at the time when there prevails a distinct decrease in the high cost of living along practically all lines. It is true that in some items the decrease is hardly perceptible. The argument may be set forth that to raise the dues under such circumstance was not warranted, and that as long as we had paddled along thus far we could well hold out for all future times. It must be remembered, however, that for the past three years the paddling has been hard and that the day of reckoning had to come.

With fifty per cent of the members of the Association serving in the Army and Navy during the war and a considerable number for many months after the signing of the armistice, a low watermark was reached in the affairs of the Florida Medical Association, and of practically all medical organizations throughout the country. It was not deemed expedient at that time to raise the dues in spite of the fact that conditions warranted such action. The high cost-level in producing THE JOURNAL was not reached until January of last year. The present necessary expenditures in producing a thirty-two page form divided equally between advertising and reading matter is thirty per cent higher than a forty-eight page form of sixteen pages of advertising and thirty-two pages of reading matter, such as comprised THE JOURNAL from its inception until we became involved in the World War. It is highly desirable, in fact almost a necessity, that we should at least return to a thirty-two page reading form, in fact not only this but an increase in the size of our type page from 5x8 to 6x9 is greatly to be desired. At the present time there are twenty-nine State-owned

Next Meeting—Pensacola—May 10, 11, 1921

Journals representing thirty-seven States. Of these twenty-two carry a 6x9 type size page and seven a 5x8.

We believe that the profession of Florida wish to maintain a creditable publication; we know that they are able to do so, and feel certain there will be no serious objection in providing for the necessary funds to carry on the work.

G. E. H.

THE FLORIDA MIDLAND MEDICAL SOCIETY.

From time to time the question of the advisability of forming sectional and district medical societies, and the effect of such organizations on the general scheme of medical organization as at present constituted comes up for discussion. The matter was discussed at the recent Conference of State Secretaries held in Chicago under the auspices of the American Medical Association. The writer was present at this conference. The general sentiment of the State Secretaries present was that no organization could exist unless it was filling a want, and that just as long as any district or sectional organization filled a want just so long did it stimulate organized medicine in general.

It has been thought at times by some that additional organizations divided forces to the detriment of the State organization. When such a condition exists the fault lies with the State organization, for with the entire State to draw from they certainly should be able to make their programs fully as attractive as any district or sectional organization could hope to do.

The organization, therefore, of the Florida Midland Medical Society is welcomed by THE JOURNAL, and it is believed that this active society will be of distinct advantage to the State Association and to organized medicine in general.

At a meeting of this society held in Orlando, October 30th, the following papers were read and discussed:

1. Case Report—Lethargic Encephalitis—T. A. Neal, M. D., Orlando.

2. Report Surgical Cases—Earl H. McRae, M. D., Tampa.

3. Difficulties in Diagnosis of Acute Appendicitis—J. S. McEwan, M. D., Orlando.

4. Value of X-Ray Diagnosis in Pulmonary Tuberculosis—A. F. Higgins, M. D., Tampa.

5. Difficulties in the Diagnosis of Gastric Disorders—Burdett Smith, M. D., Tampa.

6. Painless and Bloodless Tonsillectomy with Description of Technique — A. H. Kleiser, M. D., Orlando.

SUBJECT—*Conservation Child Life and Health.*

1. Relation of Physician—W. P. Adamson, M. D., Tampa, President Florida Medical Association.

2. Relation of Health Officer and Board of Health—Ralph N. Greene, M. D., State Health Officer, Jacksonville.

3. Relation of the Dentist—A. B. Whitman, D. D. S., Orlando.

4. Relation District Nurse — Miss Jane VanDevere, R. N. Atlanta, Director Nursing Department Southern Division Red Cross.

5. Relation School Board and Civic Officials—Jas. A. Ford, M. D., Orlando.

General Discussion opened by the Mayor: Rev. J. D. Adcock, Dr. H. M. Beardall and Dr. J. A. Simmons.

The following officers were elected for the ensuing year:

President—Dr. Earl McRae, Tampa.

Vice-Presidents — Dr. Robert L. Cline, Arcadia; Dr. John C. Knight, Plant City; Dr. Calvin D. Christ, Orlando.

Secretary-Treasurer—Dr. Rufus R. Kime, Orlando.

The next meeting will be held in Tampa, April, 1921.

G. E. H.

DEFEAT OF THE ANTIVIVISECTION INITIATIVE IN CALIFORNIA.

For the first time in the history of the struggle to prohibit experiments on animals, a prohibition bill has been submitted to popular vote. Repeatedly in the past, efforts have been made to secure abolition of animal

experimentation, or large restriction of it, before state legislatures. For more than a score of years such attempts have been made in the national Congress, Massachusetts, New York, Pennsylvania and elsewhere. In no instance has a law been enacted limiting the use of the experimental method in solving medical problems—a method which in physics and chemistry has transformed our knowledge of natural processes and placed their control in our hands. There has been universally a recognition that this method is as applicable to problems of disease as it is to problems of electricity and chemical structure. Further, there has been universal appreciation of the great medical advances already secured, and of the certainty that more are to be secured, by the use of this method.

The submission to popular decision of a question so complicated and so closely bound with emotional elements as the use of animals for medical research offered possibilities of a serious check to medical progress. In the minds of those who have defended animal experimentation, there has never been doubt that with clear understanding of the ideals, the methods and the achievements of those engaged in medical research, the great majority of our population would stand firmly against restrictive measures. The only question was whether the misinterpretations and falsehoods commonly circulated by outsiders regarding the laboratory proceedings would be believed rather than the testimony of the laboratory workers themselves. The antivivisectionists in California followed their usual routine, so roundly denounced by the English Royal Commission, of widely circulating grave misstatements of fact and reckless charges of wanton cruelty. In the October number of the *Ladies' Home Journal* and in the *Country Gentleman* for October 16th, there appeared articles making most atrocious statements regarding the treatment of animals in medical laboratories. These articles seemed to be nicely timed to affect popular opinion before the vote on November 2d, and to preclude the possibility of

reply. In one of the articles, the charge was made that "more than 800 stray dogs in St. Louis alone last year were garnered into the various medical establishments at low prices, there to be strapped to tables and carved or torn to shreds in the so-called 'holy name of science.' It was—and is—so, in nearly every city. The captured tramp dogs are hung up with spikes in them; their lips are sewed together to muffle their screams; and they are otherwise tortured; while grave-eyed scientists take copious notes on the effect of various forms of agony upon the victims' hearts and nerve centers." It is hardly necessary to answer a declaration of such abominable practices as these. An inquiry was made, however, in every medical laboratory in St. Louis, and it brought forth only indignant denial of the charges. The humane rules drawn up by the Bureau for the Protection of Medical Research of the American Medical Association are posted and carefully adhered to. What is true of St. Louis is true of establishments throughout the country.

It is well to remember that the propaganda of the antivivisectionists rests on two assumptions—wanton *cruelty* in the treatment of laboratory animals, and utter *uselessness* of the results of animal experimentation. Both lines of attack were worked elaborately by the antivivisectionists in California. Large amounts of money were contributed by eastern adherents to promote their cause, and newspaper space, posters and leaflets were used to the utmost. With limited means, the medical men and the university authorities put forth their opposing claims. It is greatly to the credit of the intelligence of the California voters that they saw through the falsehoods and misrepresentations of the antivivisectionists and registered their disapproval of the measure to abolish animal experimentation.—*Jour. A. M. A.*

CONFERENCE OF STATE SECRETARIES.

A conference of the secretaries of the State Medical Associations was held in Chicago on November 11th and 12th, under the auspices

of the American Medical Association. Thirty-four state associations out of a total of forty-nine were represented at the conference. The deliberations of the conference were conducted under the chairmanship of the genial Arthur T. McCormack, of Kentucky. It was pleasing that this honor should fall upon the shoulders of one of our southern secretaries. Doctor McCormack was unanimously chosen as chairman after Doctor Alexander R. Craig, secretary of the American Medical Association, had called the conference to order, explained its purposes and suggested we select one of our number to preside. It is not possible to report in any detail the proceedings of the conference. The secretary of the Florida Medical Association was present and feels well repaid for the time involved in attendance. The Florida Medical Association and every other state represented at this meeting cannot help but derive benefit as a result of this thoroughly good get-together meeting. Among the many subjects discussed were medical defense, state-owned journals, the need of sufficient funds to carry on state organization work, lay secretaries for the larger medical organizations, post-graduate instruction, county hospitals and many other details concerning medical organization work. Many of the subjects discussed were not applicable to societies with memberships of less than one thousand, but it is certain that every state secretary, regardless of the size of his own organization, came away enthused with his work and realized that, regardless of his present membership, be it large or small, satisfactory or unsatisfactory, there was plenty of work to be carried on in his own state. Many of the officers of the American Medical Association mingled with the state secretaries and showed their interest in our state problems. Altogether the Conference of State Secretaries was a most delightful meeting and, as stated previously, one that will bring about much good to all State organizations and organized medicine in general. Medical organization in Florida, when compared with other states, may be said to be on a fairly satisfac-

tory basis. Our State membership represents about the usual average of medical population; it is not what it should be anywhere, and Florida is no exception to the rule. We have our own peculiar problems as has each individual state. Probably the most vital problem in this state is the impracticability of maintaining active county units where the medical population is small and where distances are great. The councillors in such districts should endeavor to organize bi-county or tri-county societies, or even district organizations. Many useful members are lost to us at the present time on account of their geographical location. The matter of medical defense is deserving of consideration. We do not believe it wise at the present time for the State Association to underwrite the medical defense of its membership, but in the interests of economy some block system either involving the state membership or the separate county units should be considered.

G. E. H.

PRINCIPLE OF FEDERAL AID EXTENSION SOUND AND BENEFICIENT.

"A short-sighted view," was Surgeon General Cumming's terse comment on the opinion expressed at the recent Bankers' Convention that Federal aid should not be given to States for activities carried on in State and local communities. "In health work, especially," said the Surgeon General, "it is extremely important to recognize that the prevalence of communicable diseases in one part of the country is of very direct influence on the people elsewhere. Thus the investigations of the United States Public Health Service have clearly shown that the use of a polluted water supply in some remote rural district has often resulted in extensive outbreaks of typhoid fever in large cities hundreds of miles away; the presence of malaria in certain parts of the South has exacted a heavy economic toll from the country as a whole, for example, by raising the cost of cotton to the consumer; the Northern

investor has paid dearly for the continued prevalence of hook-worm disease in various parts of the country, for where this disease prevails labor efficiency is seriously reduced.

"When the circumstances are carefully studied it is clear that the control of disease is not merely a local responsibility, but a joint responsibility of federal, state and local authorities.

"For every dollar of federal money spent," said Surgeon General Cumming, "we have secured five to six dollars of effective health work. Under the cost-sharing principles of the existing law, the Public Health Service has been able to effect very great sanitary improvements at a very minimum of expense. It is the judgment of all who have studied the results of this cooperative effort that the principle of the federal aid extension under which this work has been carried on is not only thoroughly sound but has proven of the highest benefit to the country as a whole."

WHAT ARE VITAMINES?—BEST DESCRIBED BY WHAT THEY DO.

"What are vitamins?"

This is a question asked repeatedly since the importance of these compounds in foods has come into prominence, but no definite answer has yet been given. Investigations by scientists at universities, agricultural experiment stations, and institutions for medical research have revealed much information regarding the function of vitamins in body maintenance and building, and the parts of the various foods in which they are to be found.

That vitamins are compounds absolutely essential in food, in order to maintain the weight of the body and produce growth, has been definitely proved. The lack of vitamins causes deficiency diseases, so named because they are due to lack of something in the diet. Vitamins are present and are needed in such small quantities in the food that chemists have not yet been able to isolate them from the many other compounds which are in foods. For this reason, we know very little of the actual character of vitamins.

Three Types of Vitamines.

According to a statement by Dr. Carl O. Johns, in charge of nutrition work in the Bureau of Chemistry, U. S. Department of Agriculture, vitamins have been classified into three different types depending upon the functions which they have in promoting well-being and growth.

The first type is known as water-soluble vitamins, and these are necessary in order to obtain growth from food. Lack of these causes beri-beri, which manifests itself by disease of the nervous system and by other symptoms. These vitamins are found in seeds, in green plants, in certain bulbs and fleshy roots and fruits, and in milk and eggs, as well as in certain organs in the animal body. The seeds referred to include beans, nuts and the various cereal grains. When cereals are very highly milled in order to obtain a very fine white flour, a large part of the vitamins may be removed. Vitamins are also lost when rice is polished in order to remove the outer layers which contain most of the vitamins. It is for this reason that a diet consisting mainly of polished rice may cause beri-beri, while unpolished rice does not cause this disease.

Fat-Soluble Vitamins.

The second type is known as fat-soluble vitamins, and these are found in butter, eggs, milk, and in certain animal organs such as the heart, kidneys, and liver, and to some extent in other fats as well as in green vegetables. They also exist in smaller quantities in certain seeds. When fat-soluble vitamins are absent from the diet animals and man are subject to disease of the eyes, which appears to be related to xerophthalmia and which, if prolonged, may produce blindness.

The third type is known as antiscorbutic vitamins — that is, those which prevent scurvy, which manifests itself by disease of the bones as well as in other ways. These vitamins are found in oranges, grapefruit, lemons and other citrus fruits, and in green vegetables such as tomatoes, spinach, and lettuce, and in eggs and raw milk. The drying of vegetables frequently destroys the

activity of the antiscorbutic vitamins. The best source of vitamins is in the leafy parts of vegetables, and this is one of the reasons why spinach, lettuce, and cabbage are valuable foods.

THE OBJECT LESSON OF SALEM.

Those who read the brief dispatches from Salem, Ohio, which were carried in nearly every newspaper in America, noticed wearily that some hundreds of people were suffering from typhoid fever and that in the course of a couple of weeks fifty of them died. Then came later bulletins that the city of 12,000 in eastern Ohio, a busy little manufacturing town, just out of the district of the great Mahoning Valley steel mills and right upon the ridge of the coal fields, was recovering from the epidemic that multiplied the monthly death rate by three and reduced to danger of death one person in every ten.

The small news had but little portion of day to day interest and was dismissed as one of the incidents of national life. Few people asked themselves what it cost, nor the cost of prevention of such epidemics. For the benefit of Salem and countless other Salems all over the United States, some larger and some smaller than the little city in eastern Ohio, the Ohio Department of Health has furnished figures on what the epidemic did to the common purse.

It took the amount of the average income of upwards of 500 men in peace time. It took four times what the city collects in taxes for all purposes in a year and it took away at one swoop nearly four per cent of the property of the city. All this was in addition to the loss in suffering, in tears and in grief. The losses here given are calculated as cold economic losses without sentiment of any kind:

State appropriation	\$ 5,000
Red Cross appropriation	50,000
Municipal appropriation	15,000
Private expenditure (including medical service and drugs, 850 cases at \$50 each)	42,500
Private expenditure—nursing service 200 cases at \$100 each.....	20,000
Loss of time by wage earners (one-third of cases, six weeks each at \$5 per day)	60,000
Funeral expenses, 50 deaths at \$150 each...	7,500

Value of lives lost, employing the basis of an average of \$4,000 for each one.....	200,000
Business losses (due to lowered earning power and to avoidance of city by persons from outside), estimated at.....	50,000
Total	\$450,000

The infection came from a broken tile pipe through which the city got its water. It was laid before there was state regulations of waterworks systems. In putting down this tile pipe instead of iron pipe the city made a saving of \$1,500. It had another saving in that it had spent nothing for bacteriological supervision of water supply which would have cost \$1,000 for each year. The total saving of \$2,500 is counted against the loss of \$450,000 as calculated by the board of health experts.

State Health Commissioner A. W. Freeman, who is finishing the installation of a modern health system in Ohio and pleading with local officials for budgets generous enough to care for the simplest health needs, is looking for other Salems in Ohio and throughout the country to illustrate to them the value of "economies" such as the city of Salem made.

NEW AND NONOFFICIAL REMEDIES.

NOVASPIRIN.—A compound of anhydromethylene-citric acid and salicylic acid. For a discussion of the actions and uses of Acid Derivatives of Salicylic Acid (Acetylsalicylic Acid Type), see *New and Nonofficial Remedies*, 1919, p. 250. The dose of novaspirin is 1 gm. several times daily. The Winthrop Chemical Co., New York City. (*Jour. A. M. A.*, Sept. 27, 1919, p. 987.

STERILE SOLUTION OF LUTEIN-H. W. D.—Each cubic centimeter contains the water-soluble extract of 0.2 gm. Lutein-H. W. D., freed of protein in physiological solution of sodium chloride. For a discussion of the actions and uses of ovary preparations, see *New and Nonofficial Remedies*, 1920, p. 201. The solution is supplied in the form of Ampules Sterile Solution of Lutein-H. W. D., containing 1 c.c. Hynson, Wescott & Dunning, Baltimore.

TWENTY PER CENT AROMATIZED SUSPENSION MADE FROM BENZOATE VAN DYKE AND CO.—A mixture, each 100 c. c. containing benzyl benzoate for therapeutic use (Van Dyke and Co.), 20.32 gm.; acacia, 8.0 gm.; olive oil, 5.00 gm.; sugar, 12.00 gm.; flavors and water, to make 100 c. c. For actions and uses of benzyl benzoate, see New and Nonofficial Remedies, 1920, page 49. United Synthetic Chemical Corporation, New York. (*Jour. A. M. A.*, Oct. 16, 1920, page 1069.)

ACRIFLAVINE-ABBOTT.—A brand of acriflavine (see New and Nonofficial Remedies, 1920, page 20) complying with the N. N. R. standards. The Abbott Laboratories, Chicago.

PROFLAVINE-ABBOTT.—A brand of proflavine (see New and Nonofficial Remedies, 1920, page 21) complying with the N. N. R. standards. The Abbott Laboratories, Chicago.

BETANAPHTHOL BENZOATE-SEYDEL.—A brand of betanaphthyl benzoate (see New and Nonofficial Remedies, 1920, page 189) complying with the N. N. R. standards. Seydel Manufacturing Co., Jersey City, N. J.

BENZYL ALCOHOL-SEYDEL.—A brand of benzyl alcohol (see New and Nonofficial Remedies, 1920, page 27) complying with the N. N. R. standards. Seydel Manufacturing Co., Jersey City, N. J. (*Jour. A. M. A.*, Oct. 30, 1920, page 1205.)

BENZYL BENZOATE-VAN DYKE.—A brand of benzyl benzoate (see New and Nonofficial Remedies, 1920, p. 49) complying with the N. N. R. standards. L. A. Van Dyke, New York, N. Y.

VEN STERILE SOLUTION BENZYL ALCOHOL 4 PER CENT 2 cc.—Each ampoule contains benzyl alcohol-Ipco 4 per cent in physiological solution of sodium chloride, 2 cc. Intra Products Co., Denver, Colo.

VARGOL.—A compound of silver and a derived albumin containing not less than 20 per cent of silver. (For the action and uses of Vargol, see general articles on Silver Preparations under Silver Protein Preparations, Argyrol Type, New and Nonofficial Remedies, 1920, p. 310.) Heyden Chemical Co., New York, N. Y. (*Jour. A. M. A.*, November 27, 1920, p. 1499.)

PUBLISHER'S NOTES

A NEW GONOCIDE.

The flavines are attracting attention in this country, after a year or two of usage abroad. Derivative salts from anilin, they are said to be about twenty times more powerful than mercury bichloride while yet comparatively bland as regards any living tissues with which their solutions come in contact; phagocytosis is not retarded; and they are accredited with a penetrating power not common to germicides which, because escharotic, form a pellicle or wall behind which infectious processes go on convertly.

Of these agents "Acriflavine" has been used mostly, against infected wounds as a wet gauze dressing or packing, and also against gonorrhea. It appears to be very effective as a gonocide, especially in cases presenting within three or four days after the appearance of the discharge. Some use it

by injection in 1:1500 (physiologic salt) solution or weaker, while others claim best results from irrigation with 1:4000 solution or weaker. In many cases the agent acts almost as a specific.

Both salts (the other being "Proflavine") is being supplied by The Abbott Laboratories, Chicago, in powder form for making solutions. If desired, a 1:1000 stock solution may be made up and diluted for whatever strength is needed. A booklet of working data may be had by addressing this firm.

CONTROLLING ANESTHESIA.

When a solution of a local anesthetic is injected into a tissue its effect is limited by the rapid dispersion of the fluid; that is, the fluid is absorbed and carried off by the circulation, and the anesthesia is of short duration. True, the surgeon can control this condition when

operating upon an extremity, as a finger, by throwing a ligature around the member, but even that procedure is open to objection.

If a means could be devised to hedge about the area of operation without engorging the tissues, such a device would be in insistent demand. No mechanical invention has yet offered itself, but we have an almost perfect check on the rapid absorption of the anesthetic in Adrenalin. This substance is readily soluble; it is compatible with all local anesthetics, physically, chemically and physiologically; and it is not irritant. Furthermore, it

controls hemorrhage and, in operations on the mucous membranes, affords the operator a clear view of the field. By limitation of the absorption of the anesthetic it is possible to do an operation with less of the drug, and thereby the risk of toxic effect is minimized.

This subject is dealt with more at length in the advertising section, where the reader will find the fifth of the series of short articles on Adrenalin to which we have had occasion to refer in previous issues of this journal. A perusal of the article and its preservation for future reference are suggested.



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ORIGINAL ARTICLES

ELIGIBILITY OF APPLICANTS FOR RAILROAD SERVICE FROM A MEDICAL AND SURGICAL STANDPOINT.*

M. W. SEAGEARS, M. D.,

*Chief Surgeon, Florida East Coast Railway,
St. Augustine, Fla.*

The efficiency of man power in railroad service is directly governed by railroad surgeons; they alone are responsible for the fitness of the employee from a medical and surgical standpoint, and such a responsibility carries with it not only the safety of passengers, but that part of the great commerce of the world and with it the far-reaching influence indirectly to the millions of families and homes of the universe. The reconstruction period following the world's war, and the resumption from Government to private ownership of the railroads has left us with a shortage of man power, and at this time the applicants for railroad employment should be given a rigid examination in order to protect the lives and property of the organizations in the railroad world.

What constitutes a candidate's eligibility from the railroad surgeon's standpoint? Naturally, his eligibility must be governed by the rules and regulations of his particular railroad; from necessity the physical and medical requirements must be determined by the several branches of service and the regulations of such divisions. As a basis of comparison we will standardize our rules and group and classify as to age limit, physical examination—including vision and hearing—and general mental characteristics.

GROUP "A"—Transportation Department.

Age limit, 21 to 45; exceptions: clerks, messengers and call boys.

GROUP "B"—Maintenance of Way. Age limit, 18 to 45; exceptions: clerks, water boys and messengers.

GROUP "C"—Maintenance of Equipment Department. Age limit, 18 to 45; exceptions: clerks, messengers, call boys and apprentices.

PHYSICAL EXAMINATIONS.

"A"—Applicants for service shall undergo a physical examination, including vision and hearing. Applicants for train service, and for other positions connected in any manner with the operation of trains, shall, in addition, pass a satisfactory examination in colors.

"B"—Same as above classifications.

"C"—Same as above with the exception of Clause 46, under "United States Railroad Employees' Federation of Labor" (Maintenance of Equipment Department). (Oral notation.)

With a working basis of the above groupings the surgeon is now ready to proceed with the examination of candidates. In order to facilitate the examination, what are the medical and physical defects that disqualify an applicant for service? Among such defects are the following:

(1) Medical.

Diabetes, nephritis, pyelitis, acute and chronic cystitis, lithursis, valvular heart diseases, tuberculosis (acute and arrested), spinal nerve diseases, epilepsy, incapacitating hepatic diseases, venereal diseases, acute and chronic objectionable skin diseases, defective vision, color blindness, trachoma, or any eye disease that will affect vision, and deafness.

(2) Surgical.

Loss of thumb, or loss of two fingers on one hand, loss of arm, leg, or hand, varicose

*Read before the first annual meeting of The Florida Railway Surgeons' Association, at Daytona, May 11, 1920.

veins of both legs, or a marked varicosity in one leg, hernia, orchitis, epididymitis, hydrocele, malignant tumor, appendicitis (acute, chronic and recurrent), skull fracture followed by head symptoms, spinal injuries, severe injuries of the back, bone necrosis, acute and chronic periostitis, synovitis, and immobility of joints which incapacitates.

(3) *Blood Pressure.*

This is the most recent standard in railroad service and should be applicable as a disqualifying effect. Applicants whose blood pressure is over 150 systolic, and who have no other disqualifying physical defects, may be given the privilege of another examination, but shall not be accepted for service pending the time when he takes the second examination, nor shall he be accepted if his systolic pressure continues at 150 or over. Employees in train service, or holding other positions in any manner connected with the operation of trains, who on examination for promotion, or when periodically examined, are found to have a blood pressure of over 175 and less than 200 systolic shall be kept under observation; this, naturally, would apply to all employees who are periodically examined and who are found to have blood pressure 200 systolic or over, and such cases should be held out of service pending further physical examination.

(4) *Height, Weight and Chest Measurement Standards.*

"A"—Those who fall within the accepted standard or minimum requirements for height, weight and chest measurement as given in the Standard Tables; but no applicant should be accepted whose weight is less than 110 pounds. This rule does not apply to certain classes of service whose minimum age limit is under 18 years; for example—an applicant whose height is 60 inches should weigh 120 pounds, his chest expansion at expiration should be 31 inches, in mobility 2 inches; 68 inches in height should weigh 141 pounds, 33¾ inches at expiration, in mobility 2½ inches; 72 inches in height should weigh 169 pounds, 34¾ inches at expiration, in

mobility 3 inches. Slight variations of ½ to 1 inch are allowable in cases above 5 feet 8 inches.

EXAMINATION.

1. The candidate must be stripped. The nefarious practice of a railroad surgeon who examines a candidate for employment, and does not comply with the above rule, should cause his discharge from the service. (Oral notation.)

2. He must be vaccinated for smallpox. If he refuses, reject him.

3. Blood pressure: 150 or 175 to 200. (Oral notation.)

4. Weigh, take measurements for height and chest.

5. Vision and hearing.

6. Heart and lungs.

7. Liver and abdomen.

8. Skin, reflexes, and brain tumors.

HEARING—METHOD OF TESTING.

Place the candidate at a distance of twenty feet with one ear toward the examiner and have him close the ear farthest from the examiner by placing his finger over it. Then let him repeat aloud the words or numbers spoken in a conversational tone by the examiner, and record the distance in feet at which they can be repeated correctly; have him turn the other ear toward the examiner, and repeat the test. If the candidate is unable to hear ordinary conversation a full distance of twenty feet, he should be rejected.

VISION—METHOD OF TESTING.

(a) With a set of at least two standard cards of Snellens' Test Letters, showing letters of various sizes from 20 to 70 inclusive. The letters should be arranged in different order on the corresponding lines of each card.

(b) Standard Reading Test Card with matter printed in various types.

(c) Test spectacle frame with pink disc; or one may use a set of test cards showing semaphores in various positions.

Place the candidate to be examined so as not to face a strong light; cover one of his

eyes with the opaque disc in the test frame; place one of the cards at a distance of twenty feet from him in a clear light, but not in direct sunlight, and direct him to read the letters on certain lines as selected by the examiner, including the line marked 20. If he can read the letters on the line marked 20 correctly, substitute another card of different arrangement of letters and test in like manner; and, if he reads the letters on the line marked 20 on both cards correctly, it indicates normal vision. If he cannot read the letters on the line marked 20, have him read above 20 successively until the line is found which he can read. Record in fractions the acuteness of vision as determined with the divisor being 20 (the distance at which the matter is placed) and the denominator the number on the card showing the smallest size letters that he had read correctly. Repeat the test with the other eye, and record results. Mistakes of not more than three letters on the "20" line, two letters on the "30" line, and one letter on the "40" line will be considered as a satisfactory reading. Other lines must be read without error.

Reading Card Test: Direct the candidate to read certain letters or sentences from the Standard Reading Test Card and record the smallest size of printing read correctly at the ordinary distance of fourteen to eighteen feet. A portion of the Test Card may be covered and the candidate required to read the remainder of the paragraph. The candidate should be able to read the printing in Paragraph 2 of the Standard Card to pass the test satisfactorily. This test should be made without glasses except at the age or under the conditions where the use of glasses is permitted.

The visual standard to enter service as enginemen and firemen, Road Service, is 20-20 in each eye, tested separately without glasses; enginemen and firemen, Yard Service, 20-20 in each eye, tested separately without glasses; passenger conductors and brakemen, and baggage masters, yard conductors, yard brakemen, freight conductors and brakemen, and flagmen, 20-20 in one

eye, and not less than 20-30 in the other, without glasses; road foremen and engineers, yard masters, telegraph operators, section foremen, assistant section foremen, switch tenders, signal men, lamp men, and hostlers, not less than 20-30 in one eye and 20-40 in the other, with or without glasses; car inspectors, engine inspectors, not less than 20-30 in one eye and 20-40 in the other, with or without glasses; crossing watchmen not less than 20-40 in each eye, with or without glasses.

Applicants for service not noted in the above classifications, whose vision, with or without glasses, is not less than 20-40 in one eye and 20-50 in the other, may be recommended for acceptance for service if not barred by any other physical or mental defect.

It is compulsory for employees requiring glasses to bring the vision up to the required standard to wear glasses while on duty, and to have an extra pair of glasses with them.

RULES GOVERNING COLOR PERCEPTION.

A set of Holmgren color test worsteds, or equal, and in doubtful cases, a Williams lantern, or its equal.

Method of Testing.

Place the whole number of colored worsteds on a table in good, clear daylight. Put the test skein "light green" at a distance of about two feet from the other colors, and ask the candidate being examined to select from the heap of colors all that look to him like the test skein, and place them beside it. Have him understand that he is not expected to find an exact match for the test skein, but that he is to choose all the colors that appear to him of the same general color as the test skein, both those that are lighter and those that are darker in shade. If he does not easily understand what is wanted, let the examiner himself select the colors; then, having returned them to the general heap and mixed them thoroughly with the rest of the colors, let him call on the candidate being examined to repeat the selection. This demonstration will not enable a candidate who is defective in his color perception to select the colors correctly, and he may pick out as looking to

him like the test skein "light green" some of the greens and also some of the gray or brown confusion colors, which will appear to him of the same general color as the test skein, only varying from it in shade. Record the number of the colors incorrectly selected as being similar to the test skein "light-green," and also note whether the selection is prompt or hesitating, by writing the letter "P" or "H" on the line opposite each of the names of the colors as printed. Return all the colors to the heap and mix them together, then place the test skein "rose" two feet from the rest of the colors, and have the candidate being examined select, as before, all the colors that look to him like the "rose" skein, and record the results as for "light-green" skein.

No names should be mentioned in connection with any color in the above worsted tests, which should be based only on a comparison of colors.

If the candidate for employment being examined selects as looking like the green-test skein any of the reds, or as looking like the rose-test skein any of the greens, the candidate shall be rejected. If a candidate for promotion or reexamination makes such a selection, full report shall be made to officer to whom the examiner reports. If the candidate for employment selects some of the grays or browns as looking like the green-test skein or some of the grays, blues, or violets as looking like the rose-test skein, the candidate shall be rejected. If a candidate for promotion or reexamination makes such a selection, full report shall be made to officer to whom the examiner reports.

The selection by the candidate of one of the "colors of confusion," as matching test-skein light-green, indicates color blindness. The failure to do this, but a manifest disposition to do so, indicates feeble color perception; making correct selection to match test-skein "rose," having failed to match test-skein "light-green," incomplete color blindness is indicated. But should he in this test select the purple, the green, and gray shades also, or one of them, complete green blindness is indicated. The test with skein "red"

(which is applied only to those who are color blind as to green or red) should be continued until the candidate under examination has selected the specimens of or a greater part of the skeins belonging to this color or else one of several "colors of confusion." In this test red blindness is proven by the selection, besides the red shades, of olive green and dark brown shades of a darker quality than the red-test skein. Green blindness is proven by the selection of similar confusion of colors, but of a quality lighter than the red-test skein.

THE DEMAND FOR A BROADER FIELD OF GREATER NUMBER OF NURSES.

R. R. KIME, M.D., F.A.C.S.,
Orlando, Fla.

The nursing problem, like many other problems, has been seriously affected by the war and conditions of reconstruction since the war. The demand for trained nurses during the war was greater than the supply and has been so ever since. To meet this demand there must be a greater number trained or the demand lessened in some way; the latter is likely to increase rather than diminish. Under present conditions it is very difficult if not impossible to get enough young women to enter training to meet the demand.

One great cause of this difficulty is the present relation of the medical profession and public to the trained nurse, also the attitude of the trained nurse to the medical profession and the public. This condition will continue so long as the medical profession and public continue to employ the practical nurse on the same basis, recognition and compensation as a graduate nurse. This is unjust to the medical profession, unjust to the public, unjust to the patient and unjust to the profession of nursing. A change must be made if we expect to obtain an adequate supply of nurses and meet the demands of sick and suffering humanity.

A trained nurse, in justice, must have proper recognition according to her time

spent in training and in accordance with her fitness and qualifications. The sooner the medical profession and public recognize the difference in the training, qualifications and fitness of nurses the better it will be for all concerned, which will not detract from but add to the professional standing of the graduate nurse.

The followning classification which I gave in a paper read before the Florida Medical Association, April, 1919, I think would meet the present requirements:

- 1—The Graduate Nurse.
- 2—The Undergraduate Nurse.
- 3—The Practical Nurse.

The details of such a classification can be very easily worked out both in training schools for nurses and in nursing work. Then, as Doctor William Mayo suggests, "the training schools could give a certificate to those dropping out at the end of the first year stating they had completed one year's work, and those dropping out at end of the second year a certificate stating they had completed two years' work, and those completing the three years' course receive a diploma of graduation. The graduates, who had had preliminary cultural training, after passing suitable examinations at the state university, would be granted the degree of Bachelor of Science, as the equivalent of that which is now given for training in medicine, dentistry and other professional branches." This would give a distinctive definite classification easily understood by both professions and the public. The graduate nurse would then be entitled to register as G. N. and if she had met the additional requirements and passed suitable examinations would be also entitled to the degree of Bachelor of Science. The nurse with two years' training would be classed as an undergraduate and the nurse with one year's training as a practical nurse. Each nurse could be easily classified and given proper recognition and compensation according to her fitness and professional qualification.

The medical profession as a body should adopt some classification of nurses that will

be easily understood by both the profession and the public.

It is evident to the medical profession that much of the nursing in general medicine and in obstetrics does not demand or require the services of a graduate trained nurse; this work can be done efficiently by nurses having one and two years' training. It is also evident that a great number of these cases cannot afford to pay for the services of a graduate nurse when they could afford to pay a reasonable price for an undergraduate or practical nurse.

With this demand met, as above indicated, there is yet a wide field of usefulness and work for the graduate nurse. The graduate nurse will always be needed for superintendent of hospitals, superintendent of nurses' training schools, district nursing, operating room work, surgical cases and in severe sickness and complicated cases of obstetrics. This would give a wide range of work where such services are essentially needed and at the same time give distinctive service and proper professional recognition to the graduate nurse.

When graduate nurses have a standard fee of \$35.00 per week, then the undergraduate should receive \$25.00 per week, and the practical nurse \$5.00 to \$10.00 less per week than the undergraduate nurse.

The medical profession and the public should adhere as nearly as possible to this or some similar classification and compensation if we expect to reach a reasonable fair solution of this question. Under these conditions a far greater number of young women would enter for training in nursing, more would complete their course and quite a few would take the degree of Bachelor of Science.

Think for a moment what this would mean in the improvement of the general health and physical uplift of the public besides the saving of life and the relief of suffering. We could safely count on twice as many taking some training as do so now. Many would take one year's training to simply better qualify them for their life work in the home or as mothers or to do practical

nursing, and each would then be a center from which would radiate better influences for the uplift of the human race. A half dozen women so trained would be a blessing to any community. In fact, six months' or one year's training in the principles of health and nursing given in all girl high schools would be a blessing to humanity. Any young woman having completed the grammar school course should be admitted to the one or two years' course in training, but no one should be admitted to the graduating course that has not completed the high-school course or its equivalent. If after entering they desire to graduate, then each should take up the literary course and pass satisfactory examination before graduation.

With this classification and plan of study another difficulty could be very easily remedied, that is student nursing in smaller hospitals. Smaller hospitals meeting certain requirements might become associated with larger hospitals and give a combined course to such as desire to become graduate trained nurses, the smaller hospitals giving the one and two years' course and then the student completing her course taking at least one year's work in the larger hospital.

This again would greatly increase the number of women taking the one- and two-year courses in training and more widely disseminate knowledge of health and nursing.

In conclusion I would urge that the medical profession, hospitals, nurses' training schools and nurse associations of Florida get together on some plan that will meet the demands of humanity, increase the number of trained nurses and be of benefit to all concerned.

Since writing the above I notice The Household Nurses' Association has been formed in Boston, Mass., offering women from twenty to forty-five years of age a carefully planned course which is designed to prepare them "for the care of sickness in the home and the care of the home during sickness."

In the interest of the profession of nursing,

the medical profession and the public urgent action is needed. I would suggest as a plan for handling this subject and related conditions in the State of Florida the following:

That each hospital, training school for nurses, county medical society, nurses' state examining board and nurses' association select a delegate to meet at the same place and the day before the next meeting of the Florida Medical Association at Pensacola, May 10, 11, 1921. These delegates to form a combined association to deal with the subject of training an adequate supply of nurses, to aid in the standardizing of nurses' training schools, use its influence in standardizing hospital work, and to deal with any allied subjects thought best by the association. This body should study and discuss these subjects and recommend to the Florida Medical Association and State Nurses' Association such action and legislation as will secure best results for the nurses, physicians and the public.

If a sufficient number of hospitals, training schools for nurses, nurses' associations and medical societies respond to this by selecting a delegate and sending name, address, etc., to my address, a meeting will be called.

LABORATORY REPORTS.*

B. L. ARMS, M. D.,

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Florida State Board of Health,
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Reports of laboratory examinations are but one link in the chain of evidence in making the diagnosis of the condition existing in a given patient and should be so considered.

Does the presence of diphtheria bacilli in the throat or a positive typhoid reaction mean a case of diphtheria or typhoid in each instance.

We answer this in the negative, for we may have in the one instance a diphtheria

*Read before the forty-seventh annual meeting of The Florida Medical Association, at Daytona, May 12, 13, 1920.

carrier and in the other it may be a typhoid carrier, a recent attack of typhoid or a recent preventive inoculation.

Failure to obtain positive results from laboratory examinations in cases that strongly suggest some condition are very numerous, nor should it be considered that this indicates superficial or inaccurate examinations, for there are many reasons for this failure that are beyond the control of the laboratory.

On account of the fact that there is some misconception of the limitations of a laboratory, it was felt that a paper of this kind might serve a useful purpose, and a thorough discussion will add much to its value.

Let us now take up some of the different tests.

In the examination for the diagnosis of diphtheria whenever requested — and many times in the absence of a request — a swab examination is made, after inoculation of media, and in a great majority of instances this examination will show the presence of diphtheria bacilli if it is from a positive throat; it will also show if it is a case of Vincent's angina.

A positive result means either a case of diphtheria or a diphtheria carrier, but the diagnostician cannot tell which it is, although the clinician can, for he has all the evidence. Failure to obtain a positive result from a clinical case of diphtheria may be due to failure to swab the affected area, and this is especially true in laryngeal cases; failure to get under the membrane when one is present or to the presence of organisms that overgrow the diphtheria bacilli.

For malarial examinations blood is frequently sent that has been taken after the administration of quinine, either as such or in chill tonics.

Under these conditions long and patient search may fail to find the parasites, when if no quinine had been given they would have been found. When making examinations for malaria, if a leucocytosis or an eosinophilia is found, it is also reported.

The fact should not be overlooked that

malaria and typhoid may exist in the same patient, and if they are coexistent the diagnosis of but one is misleading; instances of the double infection are found each year, and we feel that it is wise to submit specimens for both tests, especially in the South.

As previously noticed, a positive reaction may not mean a case of typhoid, but repeated negatives after the tenth day will usually rule out the diagnosis of this condition, although there are a few instances when this will not hold in cases where the protective forces of the body are not active.

Sputum will not show tubercle bacilli until there is a breaking down of tissue with a discharge into the upper air passages, hence the diagnosis of tuberculosis should be made before the organisms are to be found in the sputum, and a single negative report should be given very little weight. Repeated negatives add cumulative evidence, but they should not be allowed to outweigh the evidence presented by the physical signs when there is a suspicious area in the lung.

In the diagnosis of tuberculosis of the genitourinary tract the laboratory is almost indispensable, and here the guinea pig should always be used for the final judgment. The writer has seen many cases where acid-fast organisms, indistinguishable from tubercle bacilli, were present in urinary sediments and they were proved not tubercle bacilli by the use of the pigs. On the other hand, they have picked up cases where long and careful microscopic search failed to find the organisms.

We frequently receive smears for the examination for gonococci that are very unsatisfactory from the laboratory standpoint, as they are improperly taken, and this is especially true in specimens taken from the female. Many of these smears are taken from the vagina with no precautions to avoid a purely vaginal smear, and even many smears said to be cervical show no evidence of care in taking, as they contain nothing but vaginal epithelium and bacteria.

Reports from such smears are often misinterpreted and misleading.

One recent case will illustrate: A patient was held for the cure of gonorrhea; two specimens sent showed no pus, and no gonococci, but a third taken properly showed many pus cells well filled with diplococci and typical of a gonococcus infection.

There are probably no laboratory reports that cause as much confusion as those of the complement fixation test for syphilis, so generally known as the Wassermann test. The name is so firmly fixed by custom that it will probably be used for all time, even though the technic employed may be radically different from that employed by Wassermann, who adapted the principles of the complement fixation test for diagnosis elaborated by Bordet and Gengou and published by them in 1906.

We are using at the Central Laboratory on all bloods a plain alcoholic antigen fixing the complement for four hours at 8 degrees C., and a cholesterin reinforced antigen fixing the complement for thirty minutes at 37 degrees C. A positive report is not returned unless the result of both are positive. There are many instances when a suspicious report should be considered positive when taken in connection with the clinical manifestations.

Frequently in early cases the cholesterinized antigen will give complete fixation before there will be a reaction with the alcoholic antigen, and on the other hand an old treated case may be strictly negative by the cholesterinized, but give complete fixation with the alcoholic antigen.

As there had appeared to be considerable confusion in interpreting reports when the result of the reaction obtained from each antigen was reported separately, we are interpreting the result of the two tests, but at any time, on request, we will give the details of the reaction, and it should be remembered that the report as rendered is the result of the serum test, and the interpretation of this result must lie with the physician who has both laboratory and clinical findings to aid him in drawing his conclusions.

Craig, in his book, "The Wassermann Test," on page 164, says: "The interpreta-

tion of the results of the Wassermann test must rest very largely with the clinician, for the clinical picture present is often more decisive than is the result of the test, and it is the clinician's place to reconcile the result of the test with the clinical picture, rather than the serologist's. The latter should simply report what actually occurs when the patient's blood serum is tested, without any reference whatever to the clinical history or the symptoms which may be present, and it remains with the clinician to interpret the report in the light of his patient's condition."

When one considers that to use Craig's statement, on page 153, "The statements here made regarding the interpretation of the results of the Wassermann test are based upon over 50,000 tests personally performed by the writer, the majority of them being re-examinations made as a control of the treatment of the disease, the remainder being upon patients presenting the symptoms common to the various stages of syphilis," it is easy to realize that he certainly speaks with complete knowledge of the subject.

We too frequently receive bloods that are not in condition for examination due to some slip in technic; one frequent cause is in using a syringe that has just been boiled and has not been dried, resulting in hemolyzing the blood. Another cause is to take the blood and, as it may not be time to ship it, to put it on ice; then when it is forwarded it will rapidly decompose.

We have found that better results are obtained from bloods that are drawn and sent at once than when the blood is centrifugalized and the serum alone is sent, nor has this been confined to a single source, but the change from many sources has been followed by a diminished number of unsatisfactory reports in each instance.

At one institution it was customary to take the specimens shortly after breakfast, and when the time of taking the blood was changed to at least three hours after eating, a marked diminution in anticomplementary results followed.

There is one kind of examination that

should be made more frequently and that is of milk. It is an easy matter to send samples of milk in such manner that the examination will be indicative of the quality of the milk as delivered to the consumers, even though it comes from a long distance.

If from a dairy, the original bottle can be sent, and if from a source that does not deliver, an eight-ounce bottle can be used. Boil bottle, cork and also a funnel with which to fill the bottle. After the bottle is filled, wrap in paper, then pack in a wooden box with ice and sawdust, and ship by express prepaid at such time that the box will reach the laboratory in as short time as possible.

In addition to examinations for diagnosis, the laboratories of the Florida State Board of Health distribute several biologics, and we wish to call your attention to them and to a few changes just being inaugurated.

Diphtheria antitoxin is carried in 5,000 and 10,000 unit sizes for therapeutic use only. The time has passed when it is considered wise to give immunizing doses of diphtheria antitoxin to contacts. The Schick test has shown that a great majority of individuals are not susceptible and it is better to take cultures from contacts and, should symptoms develop, give a curative dose.

Tetanus antitoxin may be had in 1,500 unit

packages for immunizing and 5,000 units for treatment. Antimeningococcus serum in 30 c.c. cylinders, typhoid vaccine and vaccine virus. These are free to all.

The Central Laboratory is the main distributing point, but the branch laboratories have a stock of all the above, and diphtheria antitoxin and typhoid vaccine may be had in small amounts from stations centrally located at drug stores throughout the State.

Within a very short time the typhoid vaccine will be the triple vaccine immunizing against typhoid and the paratyphoids.

Arrangements are now being made and will soon be in force whereby the first three days' treatment for the prevention of rabies will be kept at the central laboratory and will be sent out from there, the remainder of the treatment to be shipped from New York as at present direct to the physician who is to administer it. In this way two or three days will be gained in starting treatment and will be a great advantage especially in the case of face bites when the period of incubation is shortest.

In applying for any of the biologics, the request should be sent direct to the laboratory and they will be filled promptly. We are at your service and the more we are asked to do, the better we are pleased.

SPECIAL ARTICLE

AN EXPLANATION OF THE GROUP FORM PLAN OF PHYSICIAN'S LIABILITY.

General Conditions: For the past several years, a number of the leading insurance companies have been issuing policies covering the liability assumed each day by physicians and surgeons in the practice of their professions on account of alleged or real malpractice, errors, mistakes or neglect. The great majority of these claims and suits are entirely without merit and are brought, usually at the instigation of some ambulance-chasing lawyer whose sole purpose is to worry and "nag" the physician into making

a settlement in order that he may escape the notoriety, trouble and expense incident to the trial of the suit.

These suits are brought in the name of some patient who supposes, at least, that he has some grievance against the doctor or who is attempting, by this method, to escape the payment of a bill rendered by the physician for professional services.

After trying out the old method referred to, it has been found that each year the conditions were becoming worse instead of better which fact indicated conclusively that the method was wrong. It was necessary that something be done that would not only bring

about a better defense of these claims and suits but would cause insured physicians to cooperate with the insurance company and each other, to the end that *illegitimate claims may be defeated and prevented*.

Wrong Class of Men Protected: Upon making a thorough investigation into conditions, from a medical, legal and insurance standpoint, it was decided that a correction of several bad conditions was necessary.

It was found that, taking the question as a whole, the wrong class of men were being protected and that the companies were not particular enough in the selection of their risks. Men who were not eligible to membership in their local or county medical society and who were not recognized, in a professional way, by their fellow practitioners, were protected just the same as those who were eligible and recognized. The ethical men were, for this reason, compelled to assist, financially, in the protection of unethical men, through the fact that the premiums paid by both classes all went into a common fund.

Lack of Cooperation Shows: Another fact forcibly demonstrated was that there was a woeful lack of cooperation among the members of the profession itself and between the profession and the various companies writing this business. There was but little appreciation of the effect that careless comments, upon the work of attending physicians and surgeons, by others who are consulted regarding the case, will have in causing such claims to be made.

A further idea was also developed, viz., that to bring about the greatest measure of success, the best interests of all the ethical members of the profession must be considered, instead of only the question of what is best for the individual being sued. Members of the profession must work together as a unit toward presenting an impregnable defense against every illegitimate and black-mailing claim.

Many men do this of their own accord, but there are also a few that are either indifferent or who are careless and thus cause trouble

for others, possibly with an ulterior motive. The latter class are not numerous, however.

Frequent Settlements Made: The second greatest reason for the large increase in the number of malpractic claims and suits is the willingness of many physicians and companies to compromise or make settlement out of court with the idea of escaping notoriety, troubles and expense.

In doing this they lose sight of the fact that while merely taking care of the present they are jeopardizing the future. They not only injure themselves by such an action but injure every other physician and surgeon in that community. The success of one claim or suit of this character, or the obtaining of a compromise or settlement by a patient and his attorney, brings that matter to the attention of all the friends and acquaintances of both the claimant and his attorney and sows the seed of the damage-suit evil in the minds of others who then attempt to further their own interests and line their own pockets by following a similar course. As a result, the same physician or some other is sued for some real or fancied cause and is put to the trouble and worry and expense of vindicating himself.

Correction Made: The matter was squarely before the insurance companies and their task was to eliminate the causes and, by providing a satisfactory plan and an adequate policy, meet the new conditions. In doing this, they were merely following out the usual custom of getting down to fundamentals and then show the way and provide the means.

The Group Form Policy: In order to obtain the cooperation that is necessary among the members of the profession and between the profession and the insurance company, and to eliminate the majority of those who should not have this protection, it was decided to issue Group Form Policies and confine the membership in the group to those men who are members of their local or county medical society.

The Group Form Policy is issued to a group of the members of a certain local or

county medical society. Only one policy is issued and it is held by a trustee, selected from among their number by the members of the group. Each of the members of the group receives a certificate showing him to be entitled to the benefits of the Group Form Policy held by the trustee, and setting forth the name of the trustee, date of the policy, its premium period and the amount of the premium paid.

The policy contains a list of the members who purchase the insurance; this list can be added to by endorsement as members are added from time to time, as a result of further solicitation, or in the event of new members, who desire coverage, being added to the society.

Cooperation Obtained: The insurance companies have found by actual experience that a selection of risks as provided for under the group plan, and the moral effect of the plan itself, brings the physicians together with a closer personal feeling, makes them more careful in commenting upon a fellow member of the group, for should he do so, his premium is being used to partially cover the cost to defend the claim that he has, in reality, caused by his action. It is to the interest of every man in the group to keep down expense, as that is the only way in which a lower rate can be established.

The Group Form Plan also tends to discourage men from testifying against each other, as they agree, by the acceptance of their certificate, that they will always assist in the defense of the other members of the group. In the past, a great many men have had the idea that because an insurance company was defending a fellow practitioner and because that company was a large and wealthy corporation, that they might just as well testify "on the other side" and obtain the expert witness fees for so doing. They felt that inasmuch as the doctor in trouble was not paying for it, he was not being injured financially, also that there was nothing personal in their action. They lost sight of the fact that while the insurance company paid the court fees, the doctors themselves

paid the premiums and that the higher expense the company was compelled to defray the higher the premiums must be raised.

Any means by which the spirit of mutual cooperation all over the country on the part of the physicians and surgeons can be developed and stimulated will tend to assist in obtaining the passage of legislation that will improve conditions under which the profession is compelled to work. This should make the Group Plan and the efforts of the insurance companies extremely valuable to the entire ethical profession, at least among those who have the best interests of the profession at heart.

The profession should be glad to assist any company, with a reputation and financial standing, that starts out with the idea of bettering professional conditions, and the insurance companies have certainly shown that they have that intention. The profession, by its acceptance of the Group Plan, in a large number of societies, seems to appreciate the fact that the insurance company has, at least, evidenced its willingness to cooperate toward bettering conditions.

Expense: The premium for this character of protection was originally ten dollars (\$10.00), but was raised several years ago by all of the reputable companies, because the losses and expense exceeded the premiums paid. It is absolutely to the interest of every physician and surgeon to do his part in keeping the expense down in every manner possible, but a proper defense must not be sacrificed for the sake of immediate economy. It is ultimate economy that is real economy. There are five ways in which the physician and surgeon can greatly assist in lowering expense, to-wit:

1. By not making careless comments upon the treatment rendered by his fellows.
2. By trying to prevent unjust suits being filed against others.
3. By assisting in every proper manner possible in the defense of those sued.
4. By the prompt payment of premiums when due.
5. By encouraging his fellows to subscribe.

for Group Plan protection, thereby tending to decrease premium charges for each member, and also obtaining unity of action and greater benefits from cooperation.

Average Men Covered: In providing insurance in this form, the insurance companies have relieved the ethical men from paying for the defense of the men whom they do not recognize in a professional way. No one can be part of the group unless he is a member of the local or county medical society, and hence no outsider is protected. By this means a better average of men from a medical and ethical standpoint is obtained, with a consequent lowering of the hazard. This, of course, is expected to give a better experience and lower loss ratio, and make a better rate possible in the future.

A new experience is needed, one that will develop an average experience and an average rate for ethical men and this plan is certain to do it. The Group Form Plan is primarily a straightforward, honest protection for straightforward, honest men.

A New Value to Society Membership: The providing of this form of protection and the limiting of participants in its benefits to those who are members of the society adds one more reason why every eligible man should be a member of his local and state society.

Prevention: The Group Form Plan, as has already been proven, is satisfactory and is certain to prevent unjust suits being filed against members of the group, to a great extent. When the claimant's attorney knows that he is fighting a united profession, insofar as moral support of each other is concerned, and that the profession and the individual sued have back of them a corporation with all its resources and the legal talent it can employ, he will hesitate about bringing any suit against any member of the group unless he has a claim that really has merit.

In order that the maximum of success can be attained, it is necessary that the insurance companies have the active support of the best minds in the profession. These men can be of immeasurable value to the insurance

companies and through that medium, render valuable assistance to the profession itself, toward the betterment of general conditions insofar as malpractice litigation is concerned.

Compromises: The question of compromise is so important that too much stress cannot be laid upon it. It is primarily the real cause for most of the malpractice claims and suits. After a doctor is threatened or sued, the first thing that is generally proposed by the attorney for the plaintiff is a settlement out of court. He thinks more of being able to obtain this compromise than he does of his ability to obtain a judgment. It is through the means of these settlements and that they have made the most, from a financial standpoint, out of this form of litigation. Altogether too many settlements have been made by both physicians and companies, who have thought only of the present, and lost sight of the future effect of these compromise settlements.

A compromise is a direct or inferred admission of guilt and of the truth of the charges made, for this reason the reputation of a physician and of the profession generally suffers every time this action is taken.

At the best a malpractice suit causes some notoriety, many men thoughtlessly rid themselves of that condition by settlement, regardless of the merits of the claim. It is much better, from the standpoint of reputation, to have the name of having won than to have every one think the charges brought were true. One compromise makes another attempt almost certain.

Policies issued by the insurance companies, in the past, have provided that no claim would be compromised without the written consent of the assured. Such an agreement would be sufficient, if the assured would use judgment in giving the consent. The consent required is altogether too easy to obtain, as the physician will consent to most anything in his efforts to relieve himself of annoyance. A compromise is best only when there is no doubt as to the truth of the charges made and when it is a foregone conclusion that the case cannot be won. It would

be very foolish to contest a claim in the face of facts that are insurmountable. But when, as is the case in the majority of malpractice suits, there is absolutely no just foundation for an action, a suit should be contested to the court of last resort, and the class of patients and attorneys that bring these suits should be shown that every honorable means to defeat their efforts at blackmail will be used. The intention of the insurance companies is to contest every case so long as there is a possibility of winning it.

Arbitration Committee: The policy provides that "if an assured desires, in any case where there is doubt as to the advisability of contesting or settling a claim, an advisory committee of three members of the group will be selected, the assured to nominate two members of such committee and the company to nominate one member. The facts of the case shall be presented to the committee and the decision of a majority of said committee shall be binding upon both the assured and the company."

The duty of this committee is to review the case, decide as to its merits from a medico-legal point of view, and if, in their opinion, the treatment as rendered by the physician has been free from negligence and proper evidence to such effect can be produced, it is their duty to report that the case should be fought to the limit, in order to protect not only the interests of the defendant, but also those of the entire profession.

This committee is called upon only in the event that the physician sued calls upon the insurance company to compromise, or the investigation by the company shows that the case is very dangerous. The purpose is to have the merits of the claim decided by those who have no personal interest, other than in a professional way, who can render a medical decision, without any chance of their decision being influenced by fear of notoriety or expense. The insurance companies emphasize the fact that this committee, from the manner of its appointment, must be friendly to the assured, the company having the appointment of but one member. It should also be clearly noted that this committee has but the one duty and that is to give both the assured and the company the benefit of its best judgment with due regard for the best interests of the profession before permitting compromise. They have no authority to force a compromise or to in any other manner assume any control of the conduct of the defense. That phase of the matter is entirely between the assured and the company.

Any thinking man can immediately recognize the benefits to be derived from the work of this committee, and the fact that the question of compromise is so decided, will put a stop to the settlement of blackmail cases and the possibility of shyster lawyers mulcting physicians of their hard earned incomes.

(To be concluded next issue)

Cancer Department

"In the early treatment of cancer lies the hope of cure"

AMERICAN SOCIETY FOR THE CONTROL OF CANCER

WHAT EVERYONE SHOULD KNOW ABOUT CANCER.

The most recent publication of the American Society for the Control of Cancer is a handbook entitled: "What Everyone Should Know About Cancer." This is intended for an audience quite different from that reached by the handbook previously published by the Society, one which was planned chiefly for physicians. This is addressed to everyone,

and while the physician will find much of interest scattered throughout its pages, it has been prepared mainly for those who have no technical knowledge and who, therefore, wish to learn what they can, expressed in the simplest language. It is a well recognized fact that the successful treatment of cancer depends upon its early recognition, a matter

upon which the American Society for the Control of Cancer has insisted in all its publications. Such early diagnosis, however, can be made only if the person in whom the cancer has begun goes to a physician. The success of the treatment after that point depends upon the doctor himself, but up to the time of entering the doctor's office, it depends upon the patient. The extraordinary importance of cancer as a cause of death, (one person in ten after the age of forty in the United States dying of cancer), has only recently been recognized, and is not very widely known even among well informed people. Most persons delay going to a physician until the disease has extended to such a degree that the chance of successful removal is very slight, simply because they have never been told what a cancer looks like or what sensations it causes. They think that a cancer must hurt—when as a matter of fact, pain is one of the late symptoms of the disease—and also that the disease is hereditary and contagious. This handbook tells exactly what is known on these subjects: that cancer is not contagious nor does heredity play any known part in the occurrence of cancer in the human race. Very excellent advice is given in it concerning the conditions which may lead to cancer, such as sores about the mouth, rough teeth, and ulcers of the stomach; and the symptoms are set forth. The modern methods of treatment are summarized so that anyone can judge of their relative value. All forms of cancer are carefully discussed, the sections on the different types having been written by specialists, and the whole revised by a committee composed of some of the leading students of the subject, including Dr. Francis Carter Wood, Director of Cancer Research, George Crocker Special Research Fund, Columbia University; Dr. James Ewing, Professor of Pathology at Cornell University and Director of Cancer Research at the Memorial Hospital, New York; Dr. Harvey R. Gaylord, Director of the State Institute for the Study of Malignant Disease, Buffalo, N. Y.; Dr. E. E. Tyzzer, Director of the Cancer Commission of Harvard Univer-

sity; and Dr. Frederick L. Hoffman, Statistician and third Vice-President of the Prudential Life Insurance Company. These names are a guarantee that all the statements made have been carefully sifted according to the latest knowledge, so that the data in the booklet may be accepted without argument by those interested in the movement for the control of this disease.

Health departments, medical organizations or others desiring to secure this handbook for general distribution in quantity may order it through the American Society for the Control of Cancer, 25 West 45th Street, New York City, at the following rates:

5000 copies	\$175.00
1000 copies	50.00
500 copies	25.00
100 copies	5.00

Orders for fifty copies or less for personal distribution will be furnished free of cost by the Society.

PROPAGANDA FOR REFORM.

I. G. O.—According to Dr. H. S. Lambdin, Peru, Kansas, I. G. O. is: saturated solution of iodine gas in petrolatum at 130 degrees with oil of eucalyptus. The heat of the body liberates the iodine and it is absorbed as free iodine. The A. M. A. Chemical Laboratory reports that the sample of I. G. O. was a black ointment, green in thin layers, with a slight odor like crude petroleum, containing but 0.59 per cent of free iodine. (Reports of the A. M. A. Chem. Lab., 1919, p. 106.)

MORE MISBRANDED DRUGS. — Boericke and Runyon's *santonin* and *calomel* tablets, *acetanilid* and *quinin* compound tablets, *potassium iodid* tablets, and *morphin sulphate* tablets did not contain the claimed amount of drug, and some aspirin tablets contained no aspirin. *Sulferro-Sol* was falsely claimed to cure pellagra, dyspepsia, indigestion, etc. *Santal Pepsin Capsules* was falsely claimed to be a specific for all bladder trouble, gonorrhea, gleet, inflammation of the ovaries, rheumatism, Bright's disease and a number of other conditions. (*Jour. A. M. A.*, March 20, 1920, p. 818.)

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MEDICAL DEFENSE.

In a previous issue THE JOURNAL referred to the desirability of the Association as a unit taking up the matter of suitable medical defense for its membership. The Association is not, however, in a position to underwrite such protection. We present elsewhere in this issue a special article dealing with Group Form Policies. While THE JOURNAL does not subscribe to all the statements contained in this article, nevertheless the subject is discussed in a broad sense and in such a manner as to be of interest to our readers, and we believe the Group Form Policy will solve for the Association the matter of Medical Defense. Until recently those members of the profession carrying Medical Defense protection were doing so at a practically uniform expense of fifteen dollars (\$15.00) per annum. Lately two or three of the larger county medical societies have been solicited by a large and perfectly responsible insurance company with the result of from 75 to 90 per cent of the membership combining to form a Group Plan Policy. Insofar as these larger county units are concerned, there is no need for the State Association to function in their behalf; it is the small county medical society with membership of less than twenty that THE JOURNAL desires to impress with the advantages of unity of action. The Group Form Policy provides that the minimum number of members for the group be 15 in small societies and 25 per cent of the members in large societies. The larger the society and the larger percentage of members in that society to form a group, the smaller the premium. THE JOURNAL has not all the figures at hand, but in illustration a society with a membership of 100—90 per cent of these members forming a group receive a rate of eleven dollars and fifty cents (\$11.50). The four counties of Duval, Hillsboro, Dade and Escambia, which have already been written or are so in the process, will furnish at least 200 members toward the formation of a State Group. Arrangements have been made by the Secretary of the Florida Medical Association whereby mem-

Next Meeting—Pensacola—May 10, 11, 1921

bers of the association, regardless of the size of membership of their county unit, may enter into a State Group. Secretaries of county medical societies are urged to send in a list of their members desiring to enter this group. Members who already have a policy in force may enter the group at once, but their premium will not be due until such date they desire their policy to become effective.

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

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Number 9

ORIGINAL ARTICLES

TREATMENT OF PERFORATING WOUNDS OF EYEBALL, WITH REPORT OF CASES.*

JOSEPH W. TAYLOR, M. D.,
Tampa, Fla.

The use of the bulbar conjunctiva by loosening and transposing it as a means of preventing, protecting and healing corneal lesions, is probably the most salutary and far-reaching in its benefits of all the more recent acquisitions to ophthalmic surgery. It was in 1873 that the idea was first put into practice by De Wecker¹. In ablation of anterior staphyloma he loosened the conjunctiva all around the cornea back to the equator of the globe, put in purse string suture, and after excision of the staphyloma, closed the opening by drawing the conjunctiva over it. When he feared infection after extraction he resorted to the same expedient.

Three years later appeared reports of the very elaborate work of Scholer², of Berlin, along this line. Scholer employed both conjunctival grafts and sliding and pedunculated flaps, and for such diverse lesions of the cornea as perforating and non-perforating ulcers, gaping wounds with or without iris prolapse, fistulas, cystoid scars, and beginning staphyloma. Strange to say no one else took the matter up until 1884, when Kuhnt, unapprised of Scholer's work, conceived of similar measures. This he soon elaborated upon, widening their scope and refining their technique to such a degree that his name has become identified with this branch of surgery.

The methods as practiced at present are by either sliding large sections of conjunctiva over on less extensive segments, or by pe-

dunculated flaps. The graft is rarely used. The first method is particularly serviceable when the part to be covered is at or near the periphery, as cystoid scars, perforating sclero-corneal injuries, etc.

Conjunctiva-keratoplasty, up until 1914, was not used extensively in perforating wounds of the eye, due to the fear of sympathetic ophthalmitis, the more radical treatment of enucleation being the method of choice, but during the recent war there were so many eye injuries that an attempt was made to save these apparently hopeless eyes and the results were excellent in all cases where there was not too much loss or prolapse of intraocular contents, or where infection had not already taken place.

TECHNIQUE OF OPERATION.

It is advisable to make conjunctival flap and have the sutures inserted before clearing up the wound or cutting off the iris prolapse, thus lessening the risk of vitreous loss. In removing the prolapsed iris, it is always best to grasp the protruding bit and tease it out before cutting, so as to make the resulting coloboma larger than the wound and thus prevent adhesions to the edges.

Where the lens is injured, as much as possible of the swollen substance should be removed by suction, irrigation, or both. Where the wound is peripheral it is sufficient to cut the conjunctiva from the limbus along half the circumference of the cornea, with the center of the conjunctival cut opposite the corneal or limbus wound. After undermining the conjunctiva it will be found possible to draw it nearly to the middle of the cornea. The subconjunctival tissue, with its rich blood supply and abundant adhesive exudate, will seal the wound quickly and allow the anterior chamber to fill and atropin exert its influence.

*Read before the forty-seventh annual meeting of The Florida Medical Association, at Daytona, May 12, 13, 1920.

For corneal wounds more centrally placed, or for wounds extending across the cornea, a second curved cut in the conjunctiva about seven or eight mm. from the circumcorneal is required so as to fashion a bridge of conjunctival tissue, which by a suture above and below, can be drawn across the center of the cornea.

When the conjunctival flap slides over the wound care must be taken to see that there is no folding under the edges. This can be prevented by holding the edges with delicate toilet forceps as the sutures are tightened, and by pressing it out with cotton pledgets. It is important that the anchoring sutures penetrate the subconjunctival tissue so there will be no slipping. Care must be taken not to exert any pressure on the eyeball before the conjunctival flap is in position and, to make sure that it has covered the wound, atropin instilled.

Both eyes are bandaged for four days, at which time they are dressed and the stitches removed. The well eye is left uncovered, the injured eye is kept bandaged for ten days or two weeks.

By this method it is possible to save many eyes that appear to be irreparably injured, and frequently to save a useful amount of vision. I would make a plea that some such attempt be made to save these apparently hopeless eyes even if the cut passes through the ciliary body (danger zone), for if good healing takes place under the conjunctival flaps without iridocyclitis resulting, the danger of sympathetic ophthalmitis is practically nil.

If, after such an attempt at conservative surgery, there does appear infection and iridocyclitis, then the eye can be removed with only a few days lost, and long before the danger of sympathetic ophthalmitis. I believe that there are many cases at present wearing shell eyes who, had the above methods been adopted, would have had at least a passable looking eye, if not useful vision.

Greenwood³ states that he saw no patients with this justly dreaded complication (sympathetic ophthalmitis) during his service with

the American Expeditionary Forces, and in no case did severe iridocyclitis follow a well-executed conjunctival keraplasty performed on eyes showing no signs of infection at the time of operation. In writing on ocular injuries of the war, Darier⁴ had not observed a single instance of sympathetic ophthalmitis, no doubt due to the practice of asepsis from the first.

Emerson⁵ reports a case following traumatism. The sclera and conjunctiva were torn, with prolapse of the iris and ciliary body. The vitreous projected and the lens presented at the wound. The reporter abscised the prolapsed iris, dissected the conjunctiva back to the middle of the globe, and then united the conjunctiva over the cornea, putting no stitches in the sclera. The eye, which appeared to be a case for enucleation, has quieted down leaving some wrinkling of Decemet's membrane.

Ketlick⁶ believes that all gravely wounded eyes usually require enucleation, owing to the onset of inflammation and loss of vision, and reports one case as an exception to the rule. In this case there was a very extensive cut by glass of the cornea and sclera extending back over the ciliary body. The iris had prolapsed, but there was no prolapse of the ciliary and no loss of vitreous. The lens also appeared intact. The wound was covered by conjunctiva and at the end of three weeks the patient was discharged with practically normal vision.

Bulson⁷ states that where an effort to preserve the eyeball is made, the coaptating of the wound edges as nearly as possible is of importance to prevent the incarceration of iris or ciliary body. Iris entanglements are always a possible source of danger, especially in the causation of sympathetic irritation. He further states that it is difficult to place scleral stitches in the edges of the wound, and is unnecessary "if the conjunctiva is slid over the wound and carefully stitched." The conjunctival flap also has a tendency to prevent secondary infection. He advocates touching the wound edges with tincture of

iodine, or 25 per cent solution of trichloroacetic acid to counteract infection.

Let us not belittle the dangers of sympathetic ophthalmitis, but stop and consider that we are on perfectly safe grounds for the first fourteen days in trying conservative surgery, and that a plastic iridocyclitis must be present before we can have a sympathetic involvement.

REPORT OF CASES.

Case No. 1—M. S. D. Age three years and seven months.

On Saturday afternoon, May 24, 1919, this child was brought into my office from the country with a history that about four hours before she was shot in the left eye with an arrow, in the hands of a boy playmate of twelve years of age. The point of the arrow was about eighteen inches from the child and the bow was drawn full force. I give this fact that you may have some idea as to the force that struck the eye. The arrow was made from a green stick sharpened at the end. The child was having a great deal of pain when they arrived at my office.

Examination: Anterior chamber filled with blood, base of iris, portion of ciliary body and vitreous protruding. Could not determine if lens was dislocated or injured at this time due to blood in anterior chamber. The wound was a ragged tare two mm. square at upper outer angle of corneo-scleral margin.

Operation: Conjunctiva-keratoplasty was done under general anesthesia, making cut in conjunctiva one-half distance around the cornea with the center at point of injury. Sutures were inserted, prolapse cut off, and I attempted an iridectomy, but was only able to get a portion of the base of the iris, and with the vitreous protruding I did not think it wise to do any unnecessary manipulations. The eye was dressed with atropine and bichloride salve (1-3000) and bandaged.

She made a good recovery, and at the present writing the child has a good looking eye, with the exception of a small anterior synechia which causes the pupil to be oval instead of round. Lens and media clear, with very good vision.

Case No. 2—M. G. Age nine years. Female. White. Came in for treatment the night of April 7, 1920. Sent to hospital. Gave a history of having fallen out of a log cart several hours before. Examination showed a cut about three-fourths of an inch across the bridge of the nose extending down to the bone. A cut about one inch long over the right eyebrow and another cut of an inch on right eyelid, extending from inner canthus to mid-line about 10 mm. from the free margin of the lid. The eyeball was perforated above, between the insertion of the superior rectus and the limbus about 4 mm. from the latter. The lacerated wound of the sclera was between 5 to 6 mm. in length. There was partial prolapse of the iris and ciliary body the full length of the wound, also a great loss of vitreous—probably as much as twenty-five per cent.

The next morning the patient was given a general anesthetic. The conjunctiva was cut from the limbus along half of the circumference of the cornea, with the center opposite the scleral wound. It was then undermined and sutures inserted. The next step was to clear up the wound. The iris was teased out well and a wide iridectomy made. The stump was touched with iodine, then the conjunctiva was slid over the wound and sutured. No attempt was made to suture the scleral wound. Atropin was instilled, and both eyes bandaged.

The fifth day the eye was dressed. No pain since operation. Atropin was instilled and only the injured eye bandaged. On the fourteenth day stitches were removed and dark glasses put on. At the end of three weeks the patient was sent home with instructions to return at regular intervals, but should pain or blurring of vision of good eye occur to return at once. Patient at present has a good looking eye with the exception of the coloboma, but this being above is scarcely noticeable. Vision is light perception, but I think will improve to a certain extent.

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THE REMOVAL OF FOREIGN BODIES FROM THE AIR AND UPPER FOOD PASSAGES.*

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I believe the first thought of this subject by many physicians in general practice is that it can be of but little interest to them. There is a common belief that a foreign body in the throat can be easily gouged out, or even poked down out of harm with a probang or some other similar instrument. In case it has reached a deeper portion of the air passage, or unintentionally sent there by a method such as mentioned, and demanding endoscopic removal, an opinion with many of the profession is that it is indeed questionable or even a very hazardous undertaking to attempt its removal endoscopically. It is my purpose in this paper to present a different picture, and ask that you carefully study the wonderful progress of endoscopy of the past ten years. We have profited very much if we utilize this knowledge of foreign body removal and make it our rule, as it is the principle of this new science to use care and direct sight to remove any foreign body from these passages.

It is my intention in this paper to discuss in particular the endoscopic method of removing the foreign bodies. When we speak of endoscopy we include the sciences of laryngoscopy, bronchoscopy, and esophagoscopy. At present endoscopy has settled to peroral as distinguished from an earlier practice of opening the trachea to work through. A study of the reports and the most wonderful success in foreign body removal by physi-

cians in almost every part of the country is a positive commendation of the science and this particular method. It is also interesting when we consider that many of these foreign bodies were not at first suspected, the patient having been treated for some laryngeal or lung disease until the foreign body by accident or a more careful examination was discovered and removed, curing the patient.

A careful consideration of the shape, size and the composition of the suspected foreign body is necessary for the proper care and plan for removal. It would be difficult to fix the range in size that an object would be and classed as a foreign body in these passages. It is astonishing how large an object has been removed from the mouth or throat. It is surprising how small an object, if in the right location, can produce the most alarming symptoms. Small, smooth, round objects usually are carried by gravity to the most remote part of the lung and are the least apt to be removed. Small, sharp-pointed inedible substance as bones and fishbones in particular, in the majority of instances stick in the sides of the throat, as the tonsils or tonsillar pillars or back of the epiglottis. Pieces of toothpicks or straws will lodge in a similar manner. Other small sharp objects as pins, etc., held in the mouth may become caught in this locality or, during a quick inspiratory blast with the throat off guard, be carried into the larynx or lung. Pins usually turn in their descent such that the head or heavier end will be first in the descent. Flat objects as coins or flat pieces of bone usually lodge above the vocal cords or are carried into the esophagus, lodging just back of the cricoid cartilage. The reason of this is that while on the tongue they are in a lateral position while the cords are anterior posterior in position. Usually the foreign body changes position through the effort of the patient to expell unless sharp and caught tight. Their composition may be of any substance or combination so long as it will hold its identity. The composition, however, has much to do with its behavior when in the deeper air passage. Its composition also has much to do in our

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effort to locate and diagnose the case. Dr. Jackson, in his volume, "Peroral Endoscopy and Laryngeal Surgery," classifies the hundreds of foreign bodies he has removed into twelve groups, namely: Hardware, jewelry, pins, safety pins, coins and other disks, bones, meat, seeds, nuts and shells, buttons, minerals, dental objects and ammunition.

The patient's age or occupation is another important factor to consider in foreign body work of the deeper passages. According to the best statistics available at least 80 per cent are in children under fifteen years of age.

And from the same source I learn that the greater number of these are under six years of age. Dr. Jackson, in an article reporting more than six hundred cases, makes an interesting statement when he says that 91 per cent of the cases reported were charity or part charity patients. An explanation might be that the poor have less time to devote to the entertainment and supervision of the children. Such children are more apt to pick up small objects to play with unobserved or more often given small objects they should not have to amuse them.

A consideration must be given to the symptoms and the diagnosis of foreign body cases if we are to succeed well in removing them. There are certain signs and by following a certain definite plan of examination we can come to a quite substantial conclusion or diagnosis. In a great number of patients the patient himself or some reliable person can tell us considerable about the suspected foreign body. It is also true that some patients will give us a good foreign body history and the direct assertion that they have swallowed or aspirated into the lung some certain object. Malingering in these patients is no different than in other diseases and will test our ability to examine in the same manner. The most frequent foreign body that we must deal with is where some inedible substance mixed in the food catches in the throat or the esophagus, as for instance the fishbone. Something aspirated into the chink of the glottis may produce very

alarming symptoms of asphyxia and demand immediate attention to save life. The less alarming symptoms of foreign bodies in the air passages are a croupy cough, aphonia or at least an alteration in the voice and one reported by Jackson, "asthmatic wheeze." A record of the case must be made and if suspected in the oropharynx we can finish the examination by direct inspection. If beyond the cords or pyriform sinus we must resort to the use of the X-rays, auscultation of the chest, etc., to use with the symptoms already mentioned to reach a diagnosis. After we have exhausted these methods and still suspicious but not certain of a foreign body, the broncoscope can be used or the esophagoscope, as the symptoms may indicate, to explore these passages if in the hands of an experienced operator.

Now our diagnosis has been made and we are to use our information gained in the effort to get rid of the foreign body in as safe a manner as it is possible. This must be the foundation and rule that we use the knowledge gained of the position and location to work out a plan of mechanics that will avoid further injury to the patient while we are removing the foreign body from these passages. Should we not do this, the injury we may do in removing the offender may be of more consequence to the well-being of the patient than the foreign body in its place. As previously mentioned, the most frequent to deal with are in the mouth or throat above the larynx and can be removed by direct observation and the aid of the head mirror and tongue depressor. Some local anesthetic to allay spasm usually should be used. A pharyngeal or a nasal dressing forcep can be used to grasp the foreign body. Deeper in the throat we may use the laryngeal mirror, known as the indirect method, to see to grasp the intruder. Should we fail to see the body supposed to be a fishbone we may use a pharyngeal applicator with small piece of cotton and gently brush over the point that the patient says he feels the intruder. Often we can feel the cotton pass over the point ex-

posed and thus be able to see and grasp the object to remove. If the foreign body is deep in the pharynx or in the larynx and a child, as 80 per cent are, we must resort to direct laryngology. The day has arrived when any physician who aspires to special practice of the throat must be able to do direct laryngology. He may choose between the suspension and the speculum method. Personally I prefer the speculum method. After proficiency and technique have been developed through practice and experience, we will not even require an anesthetic to expose the larynx or remove a foreign body from the lung.

In all foreign body work beyond the cords or pyriform sinus it becomes necessary to use a tube. Here direct illumination and a delicate but strong and perfect working set of forceps contribute much to the factor of success. Many of the best operators today do not use a general anesthetic for their foreign body work in the trachea, bronchi, or esophagus. It is short of marvelous the seeming simplicity with which some of these men remove so many different objects from these passages. Nowhere in medicine is a knowledge of mechanics of so much assistance as in this work of endoscopy. It is the great determining factor many times of success or failure. You must be able to manipulate the object or rotate the tube or both instruments to make not only a satisfactory but a safe delivery. It is being done successfully by many physicians in many parts of the country and stands as one of the most valued additions to the practice of medicine and surgery of the past fifteen years.

MINOR EYE INJURIES.*

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Most of us are called upon frequently to treat various eye injuries, some minor and some major. Many seemingly minor injuries, however, may terminate in serious results if

not properly managed from their inception, and the object of this paper is to stress their careful treatment, and prevent, as far as possible, their assuming major proportions.

Eye injuries are the frequent cause of damage suits, both in private practice and our own special field. It behooves us, therefore, to be especially careful in handling all cases of eye injuries that may come under our care.

I assume that we are all more or less familiar with the structure and function of the eye. Suffice it to say that the lids and conjunctivæ are well supplied with blood and heal very rapidly if given a fair chance; the cornea, while not at all well supplied with blood, has a good lymphatic circulation and a rich nerve supply, and its epithelial layer is very quickly replaced, and thus superficial wounds of the cornea, when not infected, heal very rapidly. Owing to the delicate structure of the eye it is not possible to use as strong antiseptics in them as in other parts of the body; we must, therefore, rely on asepsis and thus avoid the necessity of powerful antiseptics. I may state here that the best antiseptic, in my experience, for general use about the eye, is cyanide of mercury—this is almost equally as germicidal as bichloride of mercury in the same strength, and far less irritating—and may be freely used in and about the eye in a strength of 1-10,000 to 1-3,000, and will be found to be a very efficient germicide when used in large quantities.

Just a word as to the necessary armamentarium. For anyone who expects to treat eye injuries the first requirement is good light, both daylight and artificial, and a good loup or magnifier. This can be bought, or can be made in the form of spectacles by adding a ten-degree prism base into a plus six lens over each eye; these will be found very satisfactory in searching for foreign bodies and making a minute inspection of the eye. A blephorostat for holding the lids apart, a fixation forcep to hold eye still while operating, a small scissors, a pair of small dressing forceps, a small bistoury, foreign body

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needles and spud, small needles and fine black silk and catgut for sutures.

A one-per-cent atropine solution, a half-per-cent eserine solution, two- and five-per-cent cocain solution, and a two-per-cent holocain solution. And right here let me state that when the eye is to be frequently anesthetised, holocain should be used in preference to cocain, as cocain has a very deleterious effect upon the epithelial layer of the cornea, therefore, in all corneal ulcers the frequent use of cocain aids materially in the spreading of the ulcer, adrenalin solution 1-1,000, and a two-per-cent flourescin solution for staining small lesions of the cornea, very useful for searching for small abrasions and ulcers of the cornea, argyrol solution ten to twenty-five per cent, and a one-per-cent nitrate of silver solution, and a ninety-five per cent solution of carbolic acid, for cauterizing corneal ulcers. All the foregoing, and many other combinations of eye remedies may be obtained in the form of ophthalmic ointments, put up in pointed, collapsible tubes, which greatly facilitates their application, and in many conditions are preferable to watery solutions, as they remain in the eye for a longer period, not being so easily washed away by the tears. With this modest equipment anyone will be able to handle most cases of eye injuries.

Eye injuries may be roughly divided into incised, lacerated and contused wounds, burns or corrosions, and foreign bodies in the cornea, conjunctivæ and under the lids. I will simply state that all ordinary incised or lacerated wounds of the lids may, roughly speaking, be handled as similar wounds in other parts of the body, bearing in mind that all edges must be accurately apposed, being first thoroughly cleansed, and as far as possible made aseptic, very fine sutures, of course, being used to approximate the edges, black silk being preferably used as such sutures are more easily located and removed. If the wound is in the region of the puncta or lachrymal ducts try, if possible, to pass a probe and keep patent their lumen. All cases

of burns, whether from molten metal, steam, hot water, acids, lime, or any other corrosive tend to produce an eschar, and if this involves the conjunctivæ it is very liable to produce an adhesion of the bulbar and peripheral conjunctivæ—in other words, a symblepharon—which must be prevented by all means if possible. This is best accomplished by frequently separating the parts, and, if necessary, by transplanting a strip of mucous membrane from some contiguous part, or from the buccal cavity. A large symblepharon may seriously limit the movement and function of the eye, and is to be avoided if possible. Burns produced by acids should first be thoroughly washed with weak alkaline solution, and those by lime or other alkalies should be washed with weak acid solutions—it goes without saying that in all injuries the first thing to be done is to thoroughly anesthetise the eye, as owing to its extreme sensitiveness, a thorough examination cannot be made unless the eye is anesthetised.

Now I come last to the most frequent and important minor eye injury, namely wounds and foreign bodies in the cornea. Any wounds of the cornea will heal without a resultant scar, providing only the epithelial layer is damaged, but if Bowman's membrane, which lies directly underneath, is injured, there will be a permanent scar—this is very important to bear in mind when removing foreign bodies, as any undue traumatism may produce a permanent scar, and if this happens to be in the pupillary area, will cause a permanent impairment of vision by its dispersive effect on light.

In all injuries of the cornea it is very necessary to know if there is a chronic dacryocystitis, as this condition, if present and not recognized and proper precautions taken, almost surely causes an infection of the corneal wound and results in an *ulcus serpens*, and frequently a total loss of the eye in spite of the most careful treatment.

If dacryo-cystitis is present, the punctum must be closed by actual cautery and the

wound of the cornea thoroughly carbolized, and frequently washed with as strong antiseptics as the eye will bear.

All foreign bodies should be carefully sought, and a good binocular loup is almost a *sine qua non* for their detection at times, especially if they are minute and neutral in color. In our particular field of work hot cinders, pieces of emery or metal are the most frequent foreign bodies we find, and among the employees of the Florida East Coast Railway grains of sand are frequently the foreign substance, as sand is used in cleaning out the flues of the oil burning engines.

Metallic substances are frequently made red hot by the blow which caused them to fly off and become oxidized, and this causes a small brownish deposit in the tissue of hydrate of iron, and this is often left in situ at the time of the removal of the foreign body, and is a very frequent cause of subsequent trouble, as it nearly always sets up a localized keratitis, or even an iritis and hypopyon. Unless the surgeon has a good light, a good loup, and is very thorough in his work he frequently overlooks this deposit with the consequence that the patient is laid up for some days and goes to someone else to have the operation completed, so I beg of you, if you remember nothing else in this paper, please remember that the most important feature about foreign bodies in the cornea is to remove them *thoroughly* and *completely*, and yet it is not necessary to make any extensive abrasion of the corneal epithelium to remove a small foreign body—try to accomplish your purpose with as little disturbance of the surrounding epithelium as possible, and do not penetrate Bowman's membrane if it can be avoided. Should your wound, made by a foreign body, be deep or near the ciliary region of the cornea, it is generally best to instil atropine at least once, and if feasible the eye should be closed for at least twelve hours, as the epithelium will be largely replaced in that time, and to leave an open wound in the cornea is dangerous in an unclosed eye. After the removal of even a

seemingly insignificant foreign body from the cornea or under the lids it is my invariable custom to flush out the eye thoroughly with 1-5,000 solution of cyanide of mercury and instil argyrol.

It is a good plan to make a record of the vision of each eye separately at the first visit, and to make a careful search for scars or other evidences of previous injuries, as patients sometimes attribute faulty vision to the recent accident, when as a matter of fact it is due to some former trouble.

In this day of frequent claims for damage it behooves us to be careful and thorough in our work, so we may minimize, as far as possible, this so frequent termination to seemingly minor eye injuries.

VERTIGO: AN ILLUSTRATED CASE.*

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Vertigo is a subjective sensation of a disturbed relationship of one's own body to surrounding objects in space. By vertigo is meant the disturbance of equilibration. It is just as important a symptom of disease as fever, headache, etc.

Equilibrium is maintained by the three special senses, kinetic-static, optic and muscle sense. The former is the most important (and equilibrium is its sole duty). Kinetic-static sense is like any other of the special senses, as that of hearing.

First: It has a receiving organ for the stimuli, the semicircular canals and the vestibule which, together with the cochlea, constitute the inner ear.

Second: The conducting organ, the eighth nerve and its definite tracts leading to brain centers.

Third: The interpreting organ, brain center.

Equilibrium is temporarily hampered by the sudden loss of any one of these three

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special senses and cannot be maintained unless two of the three are in perfect condition. A deaf-mute in whom the kinetic-static labyrinth sense is destroyed cannot maintain his balance in the dark or in the water, because his sight is of no use to him.

Vertigo is produced after impairment or loss of one of the senses of equilibration, but it disappears as soon as the remaining two compensate for the loss, thereby furnishing the cerebrum with the necessary facts of the position of the body.

An abnormal stimulation of the end-organ or the interruption of the nerve pathways will produce vertigo. This cerebral disturbance or the state of brain-confusion and lack of interpretation of these impulsives does not last forever, because after a varying length of time a readjustment occurs. As in seasickness the brain learns the meaning of these stimuli and an immunity results.

The internal ears and the intracranial pathways constitute the organs which keep the individual from being dizzy. The vestibular mechanism prevents vertigo by continuously keeping the cerebrum informed of the position of the body in space and its relations to objects around it.

The cause of vertigo is grouped under five different classes:

First: Lesions in the ear itself. Inflammatory and non-inflammatory. Under the former belong affections of the external auditory canal, as farunculosis, etc., and of the middle ear, suppurative otitis media or any condition causing congestion.

The non-inflammatory consists of the direct actions of the various toxemias on the labyrinth.

Second: Lesions affecting the intracranial pathways from the labyrinth, whether only a slight irritant, partial destruction or total destruction of the nerves.

Third: Ocular defects, as muscle paralysis, by giving false localization which causes confusion in the brain.

Fourth: Cardiovascular disturbances by producing ischæmia or congestion in the cranium or inner ear.

Fifth: Toxemias, by affecting any part of the ear mechanism, whether chemicals as lead or quinine, or diseases as nephritis, syphilis, etc., or local infection as teeth, tonsils or pyelitis.

Vertigo then is a disturbance of the ear mechanism, whether in the ear or in the brain. By the various ear tests, as turning in a revolving chair or douching the ear with cold or warm water, it can be definitely determined which part of the ear mechanism is affected.

The value of these tests is due to the fact that the stimulus can be sent to the brain centers from a definite point in the inner ear and the effects noted by the response of the various parts of the body. If the ear and the nerve paths are intact, all the normal responses will appear.

The examination includes the horizontal and vertical canals; each of these has its separate and different nerve pathways after entering the brain-stem.

The examination of any case of vertigo either gives abnormal or normal responses. If abnormal, the ear tests will determine the lesion either in the ear or within the brain. If normal responses are obtained, we have either, first, a purely functional neurosis, second, an ocular disturbance or an evanescent toxemia.

Case.—J. H. Age nineteen. Street-car conductor. For the past three years has had dizziness from time to time. During the past year has had two spells of dizziness, nausea, vomiting and diarrhea, but no pains in abdomen. Each attack lasted about ten days, was treated with dieting, laxatives and rest in bed.

For the past three months has had several attacks of dizziness and expulsive vomiting, often coming on when stomach was apparently empty and usually towards the end of his day's work.

He was advised to get glasses for relief of his vertigo. On taking the history, I suspected the ear mechanism, and was told that he had had a discharging ear since the age of two, but for the last two or three years had

not noticed any discharge. During this time, however, he had noticed, on clearing his throat, a foul smelling pus-like secretion. He took cold easily, had a slight cough and lost weight.

On examination the ear canal was a little moist, with a small polypus projecting from an opening in the drum. Stimulating the inner ear with water at 68 degrees, gave a very poor reaction for nystagmus and vertigo. The hearing was much diminished.

I did a radical mastoid operation which cured the suppurative otitis media. He has been perfectly free of dizziness or spells of biliousness — so called by him — since the operation and has gained much in weight.

In conclusion, would say that the two severe attacks were due to circumscribed labyrinthitis, and the lighter attacks of vertigo and vomiting were caused from irritation of the labyrinth from the suppurative otitis media. The eustachian tube being patent, carried off most of the discharge to the throat, which of course kept the suppurative ear disease hidden.

THE ACUTE SURGICAL ABDOMEN.

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The acute surgical abdomen as a name for conditions or pathological processes arising in the abdominal cavity has been criticized by some of the hypercritical or ultra conservative members of the profession; however, it expresses a condition of which every surgeon knows the meaning.

The acute surgical abdomen does not necessarily mean that we are facing virgin pathology, as many, and I might say most cases, are the result or sequelæ of chronic pathological processes which have a well-marked history, which, if properly elicited, will be a great aid to the diagnosis. Diagnosis is the most important function the physician has to perform. When the diagnosis is made and you are sure you are right, then and not until then should anything be given for the relief of pain, and it were better to defer it

then until the patient consents to an immediate operation, for relief from pain often causes the patient to be harder to convince that he needs an immediate operation, and thus valuable time is lost. Purgatives should never be given until you know your pathology, even in simple abdominal pain, with or without fever.

This may seem to some of you unnecessary advice, but I am sorry to say that the indiscriminate use of purgatives is almost as bad among the medical profession as among the laity.

Those among you who do surgery can recall patients, where the attending physician has proudly informed you of the thoroughness and effectiveness of purgatives administered by him in cases of simple appendicitis, which were almost invariably converted into localized abscess or diffuse peritonitis; likewise he will tell you how vainly he has tried to move the patient's bowels in acute obstruction.

John B. Deaver has very eloquently said: "I hail the opportunity of censuring this cursed practice. The doctor and the laity should also know the harmful possibilities of the purgative. Would that my voice were strong enough to penetrate to every home in the world, and if heard there, my advice were heeded, in order that this malicious practice might be relegated to the oblivion it deserves. Mothers, and all who use the family medicine chest, must be made to realize the danger of using a purge in an acute abdominal crisis. In these conditions it should never be used except upon prescription by a doctor, who himself is informed as to its dangers."

Purgatives in the acute surgical abdomen cause the mortality to be out of all proportion to what it should be. A carefully taken history is the sheet anchor of the surgeon in diagnosing the acute surgical abdomen. It not infrequently is a secondary condition or an acute exacerbation of a chronic pathological process, which has given evidence of its presence for a more or less definite period of time, such as chronic ulcer of the stomach or

duodenum, gallbladder disease, chronic appendicitis, hernias of long standing, ovarian cysts and tubal disease, previous operations which may be followed by adhesions which in turn may cause acute obstruction, traumatism (even where no external injury is discoverable), typhoid fever (especially the ambulatory type), ectopic pregnancy and numerous others, all of which are important in arriving at a diagnosis.

Physical Examination: Here as nowhere else does experience and judgment score "ace high." Pain, tenderness, and muscular rigidity are the most common physical signs and the most valuable; facies, pulse and temperature have their value as does also posture; the differential blood count is an aid, but not infallible, and to wait for a leucocytosis is sometimes fatal.

I shall not attempt to tell you how to diagnose all of the conditions which go to make up the acute surgical abdomen, but I wish to reiterate that a correct diagnosis is of the uttermost importance. There are several conditions which must be differentiated from acute abdominal disease, or calamity may overtake us. Pneumonia with diaphragmatic pleurisy, the gastric crises of tabes, acute enteritis and acute dilatation of the stomach, all of which have at times been mistaken for surgical conditions.

The more common of the causes of acute surgical abdomen mentioned should be recognized readily if you study your histories carefully and make careful physical examinations. The pneumo-peritoneum and roentgenology have wonderful possibilities in diagnosing the intraabdominal problems of the future. There will at times be conditions which none of us can diagnose without exploratory operation, but if you know it is a surgical condition, then operation is less dangerous than waiting for an absolutely positive diagnosis.

The tendency of most perforative lesions is to rapidly become generalized, especially in the upper abdomen. Conditions commonly seen in the lower abdomen have more tendency to localize if treated properly.

I place all patients with fever and abdominal pain in Fowler's position and transport them in that position or in a sitting posture when it is necessary to move them before operation. I often operate in the home rather than move a desperately sick patient, and I know that some lives have been saved by so doing.

When to Operate: This is unfortunately not always a matter of choice with the surgeon. He often sees his patient "too late for an early operation and too early for a late operation." This is the time when the surgeon needs the one essential qualification, I should say the greatest qualification a surgeon can have. *Surgical Judgment:* All perforative conditions, especially of the upper abdomen, should be operated on at the earliest possible moment, because they become so rapidly generalized. Lower abdominal conditions should be operated on early if seen early in the disease, but when seen late, much can be done by postural treatment and physiological rest, or the Oschner-Fowler-Murphy treatment. This treatment is applicable in diffuse peritonitis when seen late and will save many lives by converting a diffuse into a localized peritonitis.

The operative treatment will depend entirely on the condition present and the time the patient is seen by the surgeon. There are two things which I wish to emphasize in the operative treatment of the acute surgical abdomen. *It is a good thing to know when to quit, and, when in doubt, drain.*

EMPHASIZING SOME FEATURES OF ACUTE PYELITIS IN THE ADULT.*

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No attempt will be made in this paper to present a classical dissertation of the subject, but only to call your attention to a few salient features of the disease, because of its importance and frequency, and our failure at times to recognize it.

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It is an infection essentially of the female, both in the adult and children. The chronic infection is often seen in men.

The Chill: Many infections manifest their onset with chills or chilly sensations, but acute pyelitis will, in the majority of cases, show its onset in a distinct chill; that is, the physician will not be summoned until the advent of the chill. The patient may have had for several days vague aches and indisposition, but nothing distinctive until the onset of the chill. The chill may be mild or severe, of short or long duration, followed by fever and sweat, the sweat often of profuse nature. These are the cardinal symptoms of acute intermittent malaria, and unless we are careful we are liable to err and prescribe a purgative and quinine.

The History: A careful interrogatory will often elicit an irregularity and a lack of periodicity of the chill or chilly sensations. Sometimes the chills occur three or four days apart, and again there may be two or three chills in twenty-four hours.

Pain: The general body aches resemble any infectious process and are widely distributed. Pain, however, is experienced in the passage of the urine and located at the meatus, often tenesmus and burning immediately following micturition. Pain may be present in the kidney and along the course of the ureter and pressure over these structures may elicit tenderness.

In some cases pain along the urinary tract is so severe that renal colic is suspected. This is due to attempted passage of thick inspissated pus through the ureter. In such cases catheterization of the ureters and an X-ray examination offers a differentiation.

Urine: The urine is usually of a light color, cloudy and contains more or less sediment. The sediment rapidly settles and is chiefly composed of pus, rarely blood cells, and a microscopic examination of the sediment usually reveals the true constituents. It is advisable to examine a twenty-four-hour specimen of the urine or urine passed at different intervals, as an obstruction to the outflow of urine from the pelvis of the kidney

may be occasioned by the thick collection of pus along the ureter. In such instances there will likely be pain and evidence of a tumor in the kidney region due to the retained urine.

Blood: As in all infectious disorders, the blood should be examined. There is usually a leucocytosis.

Treatment: The treatment consists in the alternating use of agents which render the urine actively acid and alkaline, and hexamethylene. The patient should be in bed and a purgative ordered. Ten to twenty or more grains each of hexamethylene and acid sodium phosphate may be given three times a day, after meals, for three or four days. Then alkalize the urine for three or four days with citrate of potash, sodium bicarbonate or other alkaline salts. These agents should be administered alternately until the urine is free from pus and all symptoms disappear. Employ then for a shorter or longer period smaller doses of hexamethylene. A bland, non-irritating diet is suggested. Always caution the patient that the disease is liable to recur. The recurrence may be due to an infected focus elsewhere in the body, or failure to eliminate entirely the infection in the kidney pelvis. The prolonged and severe cases may require local treatment to the kidney pelvis through the ureter.

PROPAGANDA FOR REFORM.

A COUNCIL ON PHARMACY AND CHEMISTRY FOR THE NETHERLANDS.—The minister of labor of the Netherlands officially inaugurated, on September 1st, the government Instituut voor Pharmaco-Therapeutisch Onderzoek, which seems to be modeled after the Council on Pharmacy and Chemistry of the American Medical Association. The minister of labor remarked in his opening address that the Netherlands has had a permanent pharmacopeia commission since 1899. But this does not attempt to keep pace with the flood of new remedies, and the government has finally heeded the appeals of the Netherlands Medical Association and the Pharmaceutical Association and has founded this institute. The Council on Pharmacy and

Chemistry of the Netherlands is to have the support and backing of the government; the Council on Pharmacy and Chemistry of the American Medical Association has only the backing of the medical profession. (*Jour. A. M. A.*, November 6, 1920, p. 1219.)

MISBRANDED VENEREAL NOSTRUMS. — The following products have been the subject of prosecution by the federal authorities on the ground that the therapeutic claims made for them were false and fraudulent: Musser's Capsules (Musser-Reese Chemical Co.), consisting essentially of copaiba balsam and oil of santal with indications of oil of cubebs and oil of mace. Dr. Sanger's Capsules (Edward J. Moore Sons, Inc.), consisting essentially of copaiba, cubebs, santal oil, matico, licorice root and magnesium oxid. Rid-It Caps (S. Pfeiffer Mfg. Co.), consisting essentially of salol, oils of juniper and sassafras, turpentine, a fixed oil and coloring matter. Black and White Capsules (Wilson Drug Co.), consisting of capsules containing hexamethylenamine and of capsules containing a mixture of volatile oils, including cubebs and copaiba. Benetol (Benetol Co.) consisting essentially (in agreement with a previously reported analysis by the A. M. A. Chemical Laboratory) of alphanaphthol, soap, glycerin, water and traces of essential oils and alcohol. G-U-C Capsules (Hollander-Koshland Co.), consisting of a sulphurated oil with volatile oils, including copaiba, cinnamon and santal oils. Merz Santal Compound (Merz Capsule Co.), consisting of balsam copaiba, cassia, sandalwood oil and a sulphurated oil. Enoob Antiseptic Injection and Capsules (Tropical Cooperative Co.), the "injection" being essentially a solution of phenol, menthol, thymol, boric acid and zinc sulphate in water, and the "capsules" consisting essentially of cubebs, copaiba, gum turpentine and pepsin with indications of santal oil. White Swan Injection (Stacy Chemical Co.), essentially a watery solution of boric acid, salts of aluminum, zinc and ammonium, glycerin

and phenol with bismuth subgallate in suspension. (*Jour. A. M. A.*, November 6, 1920, p. 1285.)

HELPING THE COUNCIL.—There are many physicians who, while figuratively patting the Council on Pharmacy and Chemistry on the back, do nothing to aid its efforts. On the other hand, there are men in the profession who give the Council active support. Such a man wrote to a pharmaceutical concern that he was receiving advertising concerning its products and suggested that until these products had been accepted by the Council, it was a waste of postage to send this. He explained that he depended entirely on the Council in such matters as these. (*Jour. A. M. A.*, November 6, 1920, p. 1215.)

FORMICIN OMITTED FROM N. N. R. — Formicin, manufactured by Kalle and Co., A. G. Biebrich a. Rh., Germany (Kalle Color and Chemical Co., New York, U. S., agents), was admitted to New and Nonofficial Remedies in 1912. The Council on Pharmacy and Chemistry reports that while the claims recently made for Formicin were essentially those made when the product was first accepted, these claims were questioned because further experience had not established the usefulness of the product. As the Kalle Color and Chemical Co. presented no evidence to establish its therapeutic efficiency, the Council directed the omission of Formicin from N. N. R. (Reports Council Pharmacy and Chemistry, 1919, p. 76.)

PRODUCTS OF THE AMERICAN ORGANO-THERAPY Co.—Dr. Alfred A. Lowenthal has announced a "Post Graduate Course of Lectures and Clinics" to the physicians of Chicago, Denver, St. Louis, Columbus, etc.—and incidentally brings to the attention of the medical world the alleged virtues of the products of the American Organotherapy Company. A few years ago, the American Animal Therapy Company of Chicago put out such products as Lymphoid Compound (Lowenthal), Ova Mammoid (Lowenthal) and Prostoid (Lowenthal), and these products were exploited to the public. (*Jour. A. M. A.*, July 3, 1920, p. 49.)

MORE MISBRANDED NOSTRUMS.—The following products have been the subject of prosecution by the federal authorities charged with the enforcement of the Food and Drugs Act: Linonine (Kerr Chemical Co.), held misbranded on the ground that the curative claims were held false and fraudulent. Valentine's Sarsaparilla Compound with Potassium Iodide (Allan Pfeiffer Chemical Co.), sold under therapeutic claims which were false and fraudulent. Olive Branch (Olive Branch Remedy Co.), misbranded in that the curative claims were false and fraudulent. Prince's Pills, Liniment and Tru-Vigor Nerve Tablets (Boston Drug and Chemical Co.), misbranded in that the therapeutic claims made for them were held false and fraudulent. Mrs. Summer's Absorbent Pile Remedy, Mrs. Summer's Womb, Ovarian and Kidney Tonic and Vitalizer Tablets and Mrs. Summer's Heart, Brain and Nerve Pills (Vanderhoof and Co.), misbranded in that they were sold under therapeutic claims which were false and fraudulent. Compound Syrup of Hypophosphites, Bromo Febrin, Hystoria, Aromatic Cod Liver Oil, Red Cross Kidney and Liver Regulator, White Pine and Tar Syrup, and Boro-Thymine (Cal-Sino Co.), misbranded in that the therapeutic claims were false and fraudulent (some were also held adulterated because their composition was misleadingly or falsely declared). (*Jour. A. M. A.*, December 11, 1920, page 1663.)

IRON, ARSENIC AND PHOSPHORUS COMPOUND.—The Council on Pharmacy and Chemistry reports that Hypodermic Solution No. 13 Iron, Arsenic and Phosphorus Compound (Burdick-Abel Laboratory) was found unacceptable for New and Nonofficial Remedies for the following reasons: (1) It does not contain ferrous citrate as claimed; instead, the iron is in the ferric condition, apparently in the form of the unofficial and unstandardized "iron citrate green" for which there is no evidence of superiority over the official iron and ammonium citrate. (2) Its name gives no information on the form in which the iron, the

arsenic or the phosphorus occurs therein. The term "arsenic" does not indicate that the preparation contains the mild cacodylate. Nor does the term "phosphorus" tell that it contains the practically inert sodium glycerophosphate. (3) The preparation is unscientific because (a) it is irrational to prescribe iron and arsenic in fixed proportions; (b) there is no evidence that the hypodermic or intramuscular administration of iron has any advantage over its oral administration, and (c) glycerophosphates have not been shown to have properties other than inorganic phosphates, and hence the administration of sodium glycerophosphate as a hematinic is illogical. (*Jour. A. M. A.*, November 13, 1920, p. 1358.)

THE PARRY MEDICINE CO. BARRED FROM THE MAILS.—For some years Pittsburgh has harbored a quack concern known as the Parry Medicine Company. The president of the company was one Leonard L. Parry, who advertised himself as "Dad Parry, the Healer" and also as "The Miracle Man." In April, 1917, Parry, who is an obviously ignorant faker, was arrested and convicted of the illegal practice of medicine and was sentenced to pay a fine and to serve a six months' sentence in jail. Apparently as soon as Parry got out of jail he went right back to his quackery. As a result the federal authorities took action, and the Parry Medicine Co. has been denied the use of the mails. The "medicines" put out by the Parry concern were fourteen in number and were numbered consecutively. They were essentially the same in composition, differing only in flavoring. Each was composed approximately of alcohol, 25 per cent; water, 25 per cent, and olive oil, 50 per cent, to which was added a few drops of essential oils. No. 1 was for tuberculosis, lungs, bones or flesh, gallstones or tapeworm. No. 2 was for cancers, adenoids, hemorrhoids, piles, asthma, goiter, typhoid and all other fevers. Extensive curative claims were similarly ascribed to the remaining twelve preparations. (*Jour. A. M. A.*, December 18, 1920, p. 1732.)

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Next Meeting—Pensacola—May 10, 11, 1921

AN EXPLANATION OF THE GROUP FORM PLAN OF PHYSICIAN'S LIABILITY.

(Concluded from February Issue)

No Restriction as to Class of Case Covered:

There are many other advantages to this Group Form Plan, one of which is the fact that it is a general coverage without restrictions such as have been in evidence in policies issued heretofore. Any claim for damage arising by reason of the practice of the assured's profession is defended and loss covered, *until, if ever*, it shall have been legally established that the damage was caused by an unlawful act, or caused by the assured or an assistant while to any extent under the influence of intoxicants or narcotics.

All other policies issued by reputable companies seem to limit the coverage to cases wherein there are bodily injuries or death suffered. Owing to developments during the last few years, this does not include, by far, malpractice liability. Cases such as for errors in diagnosis, which are becoming very common, cases based upon quarantine, autopsies, inquests, prescribing and dispensing, etc., may not be bodily injury cases. Hence they would not be covered by a policy that was so limited.

Contract Work: Most other policies issued to cover this form of liability do not cover work that is done on a salary or on a commission basis; in other words, contract work. It is excepted unless an extra premium is paid. The Group Form Policy covers this and all other classes of service performed in a professional way.

Assistants: The question of the coverage for the errors or neglect on the part of assistants is an extremely important one to the profession. Most policies require that these assistants be named in the application. The insurance companies maintain that it is impossible for any physician or surgeon to name, at the time of making application, those who will assist him during the following year. You will note that the Group Form Policy includes in its coverage all of the

errors of omission and commission on the part of all qualified assistance of the assured without requiring them to be named in the application or elsewhere. Also note that the question of nurses is taken care of and is included in the coverage, while it is problematical whether or not a nurse is covered in other policies. Certain it is that no direct mention is made in any recognized policy.

Financial Limits of Group Form Policy: The Group Form Policy provides for unlimited defense in each case and indemnity for payment of judgments to the amount of \$5,000 in any one claim, with \$15,000 total loss payments on account of acts committed during any one year, for each member of the group. The defense expense is not included in the limit of \$5,000, but is to be paid in addition thereto.

Moral Assistance: It will be noted that each member, by the acceptance of his certificate, agrees that he will assist the other members in the event of trouble, which agreement is valuable in that it tends to eliminate the chance of one member carelessly doing an injury to another. If the members will work together, there is little chance for an unjust suit being started, as the attorney for the plaintiff needs the assistance of other physicians in order that he may make his case.

Cancellation of Policies: The question of the cancellation of a policy is also an important one. Cancellation of policies has been known to work an injustice to some physicians. Attention is called to the fact that the Group Form Policy cannot be cancelled as to any assured, except at the expiration of his premium term, unless the assured is expelled or resigns from membership in his county society which action automatically cancels it. The companies reserve the same right to themselves and expect that the assured will keep the policy for its full term. A notice of thirty (30) days is required for cancellation by either party as at the end of the premium term which precludes any chance of an assured being injured. The cancellation may be made in the manner mentioned either by the assured for himself or

by the trustee for him or for the entire group should a majority of the group desire cancellation and so instruct the trustee.

Rates: Rates for the Group Form Policy are based upon the percentage of the society members accepting the coverage. The minimum number of members for the group is 15 in small societies and 25 per cent of the members in large societies. The rates are in accordance with the instructions and rate sheets issued by the companies applying to the different states. The second and each succeeding year, the rate for that year will be determined by the per cent covered sixty days prior to the anniversary date of the policy. Should a society obtain 25 per cent to start with and increase it to 50 per cent in the following ten months, the rate for the second year would be that named for 50 per cent membership. If a society should obtain 50 per cent to start with and during the year a sufficient number would drop out to reduce the percentage below 50 per cent then the rate would revert to that named for 25 per cent membership.

New Experience: Owing to the nature of the Group Form Plan and the results the companies are certain will be developed, it is expected that a much better experience will be shown with a lower loss cost and expense ratio than has been shown during the past few years on the individual plan now used by many companies writing this kind of insurance.

Rates for Group Plan insurance will be based wholly upon the experience under this plan. It is to the advantage of the physicians to assist in developing a better experience by according the insurance companies their moral support in preventing and defending unjust suits and also in increasing the business under the plan because the greater volume of business written can be expected to improve the average risk, and produce a better average experience.

The members of the various groups have the full assurance that the rates will not be raised unless the experience under this plan

requires it. Also, the rates will be reduced if the results warrant such action.

Premiums paid on the group form will be spent only in the defense of local or county medical society members, men who are recognized in a professional way as being men worthy of the support of ethical men. Premiums will also be based upon a sufficient amount of business to bring about a fair average.

Premiums will not be based upon the experience of one state but upon the results as shown in several states where legal and medical society conditions are similar. This will eliminate any chance of men in one state paying a rate that is excessive.

Signing the Application: In signing the application, the prospective member will place before his signature the current date if he desires his coverage to start immediately. If he desires it to begin at the time of the expiration of a policy that is still in force, he may place the date before his name. His premium will be due and payable on that date and his coverage will begin at that time. In this manner their business can be secured in advance of expiration and you have as an excuse for obtaining it in advance the fact that it is necessary to know the percentage of members who will be covered within the first year so that the rate may be made for those desiring coverage at once. In signing at once, they are assisting their fellow practitioners in obtaining a better rate and are also showing that they intend to accord the company their moral support in the time elapsing before their actual coverage commences.

Claim Department: The companies desire to call attention to the fact that their claim departments are open at all times to inquiry from any member of the group. It can easily be seen that many claims can be stopped in their earliest stages if taken up intelligently with the claimant, and in that manner the companies can save the expense of litigation and the assured can save the worry and the notoriety. A member should not wait until claim or suit is actually filed before the companies are notified of the conditions existing,

though failure to do so does not mean that the member is not entitled to full consideration. It is simply advised as it is the better course.

Counsel: The selection of counsel is a very important item. Unusual care is taken by the companies, as a man that has the required ability is necessary, he must fit the conditions locally and have the proper relations with the assured. Many a case of malpractice has been lost because of the antagonism of the local press toward the attorney, they taking that opportunity to oppose him for political or other reasons. A man of first-class ability is necessary to bring about a successful termination of the suit.

Proper Records Should Be Kept: It should be impressed upon all physicians that there is great need for them to keep full and sufficient records of their treatments and consultations. Copies of all prescriptions should be kept. X-ray should be used in all cases of fractures and each plate should be so identified that there can be no chance of doubt as to the case it applies to. A case recently came to our notice of the wrong plates being purposely placed in evidence to show that a fracture existed. It happened that the physician taking the plates made it his practice to properly label them, and he was able to show that they were not the plates that he had taken.

Court Changes: During the last few years there has been a marked change in the action of the courts in reference to malpractice claims and suits. There has been a change in the rules of evidence and in the methods of court procedure that has rendered the chance of vindication more doubtful. It is a well-known fact that juries delight in rendering verdicts against the physician, for about the same reason that they treat a corporation in the same manner. It is in connection with these facts that it is found so necessary to have the cooperation of the profession and it is insisted that the selection of proper attorneys is an important matter, one that requires careful study of conditions and all other phases of the work.

Appeal Bonds: Another difference in the methods applied under this plan is that in the event of an appeal being taken, appeal bonds are necessary. The insurance companies are in a position to and will furnish these bonds without cost or security being required of the assured in the amount of protection purchased. A physician cannot usually afford to give these bonds or furnish collateral security to the company furnishing the bond without serious inconvenience in a financial and business way.

General Purpose: The policy under the Group Plan is to better conditions wherever it is possible. The advice of the best minds of the profession is wanted, for many valuable suggestions could come from them and their moral support will be of immeasurable value. The primary purpose of medical societies is to promote harmony and correct practice; this plan is certainly intended to assist in developing greater efficiency along similar lines.

Termination of Membership in Society: The interpretation of this phrase as used in a Group Form Policy is that expulsion from the society terminates the membership; official action by the society, with the effect of dropping any member from their roll and making necessary the reelection of such member by further official action by the membership committee, will be considered the basis upon which the termination of the insurance will be effective.

Temporary suspension of some of the privileges of membership incident to the failure to pay annual dues when due, is not considered a reason for the termination of the coverage, and, further, the official action as above indicated will always be considered the determining feature.

Continuous Form Policy: The Group Form Policy is prepared with a view of affording continuous insurance; the continuation of each assured's insurance being dependent upon two features: First, the payment of his premium; second, continuance of his membership in the society. Each assured

under the Group Form Policy may be certain that his insurance will be continued in full force and effect without further attention by him than the payment of the premium when due, and it will not be necessary for him to make a second application for the insurance unless it has been cancelled by one of the foregoing causes, in which event cancellation memorandum will, as a matter of record, be issued showing the date upon which his insurance ceased to be effective and copy thereof furnished to the assured. If the assured's protection has been terminated by the nonpayment of premium and he desires to reinstate his insurance under the policy, then it will be necessary for him to sign another group application, and the insurance will be reinstated as of the date of such signature or a later date appearing opposite his name in such application.

Ownership or Part Ownership of Private Hospital: The utmost care should be taken to call every physician's attention to the fact that physician's and surgeon's liability insurance only covers the loss that arises on account of the practice of medicine and surgery and is not intended to, nor will it cover the loss that arises by reason of the fact that the physician, in addition to practicing his profession, operates a business enterprise of any kind, even though such business enterprise is a private hospital, sanatorium or other health resort.

The term private hospital used above is applied to those non-incorporated institutions owned and operated by one or more doctors in which the employees of the institution are the employees of the physician or his associates.

NEW AND NONOFFICIAL REMEDIES.

MERCURY (MERCURIC) BENZOATE-SEYDEL.
—A brand of mercuric benzoate (see New and Nonofficial Remedies, 1920, p. 181) complying with the N. N. R. standards. Seydel Manufacturing Co., Jersey City, N. J. (*Jour. A. M. A.*, December 4, 1920, p. 1569.)

CULTURE OF BACILLUS BULGARICUS-COLEMAN.—A pure culture of *Bacillus bulgaricus*, marketed in bottles containing about 90 c.c. This culture is stated to be suitable for all purposes for which *Bacillus bulgaricus* is used (see general article on Lactic Acid Producing Organisms and Preparations, New and Nonofficial Remedies, 1920, p. 156). Coleman Laboratories, Wheeling, W. Va. (*Jour. A. M. A.*, December 18, 1920, p. 1717.)

PNEUMOCOCCUS GLYCEROL VACCINE (TYPES I, II, III POLYVALENT)—LEDERLE.

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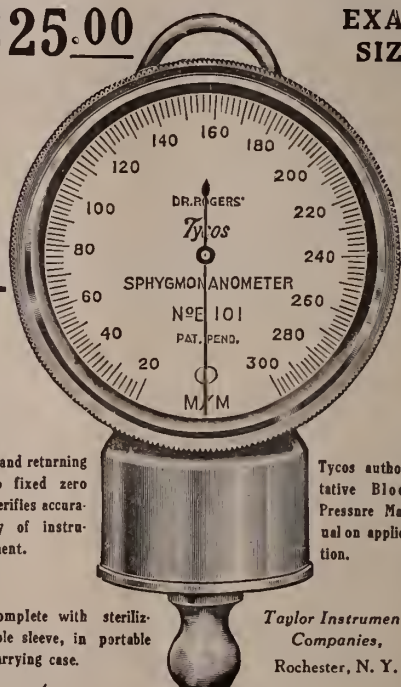
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ORIGINAL ARTICLES

SOME OBSERVATIONS ON THE NON-SURGICAL DRAINAGE OF PATHOLOGIC GALL-BLADDERS.

GEORGE M. NILES, M. D., and
H. N. KRAFT, M. D.,
Atlanta.

Patients with pathologic gall-bladders, like the poor, are always with us. Chronic infections of varying etiology, resulting in many forms of illness and physical discomfort are constantly claiming our attention, are seeking relief at our hands. Some of these pathologic gall-bladders, especially cholelithiasis, would appear frankly surgical, and many instances can be relieved only by that means. However, surgery of the gall-bladder tract is not always successful, as many surgeons will admit. Mayo's statistics show that 15 per cent of operative cases are failures. Then we must consider the end-results after cholecystectomy and cholecystotomy. The surgeon dismisses the case after a necessary rest in the hospital, a period of dietetic quiet to the digestive tract and all the psychic stimuli that accompany a surgical operation. For a while all is well; then come the "echoes," not always brought to the surgeon, but more often to the gastroenterologist or the internist. Recurrences of the original symptoms, plus adhesions in the right upper quadrant of the abdomen are quite common, and in the meanwhile the unfortunate patient is loath to again invoke the knife. Any method, therefore, which holds out reasonable hope of benefiting such conditions by non-surgical means is necessarily of interest.

In April, 1917, Meltzer published as a footnote to an article the following:

"In experimenting with magnesium sulphate, I observed that the local application of a 25 per cent solution of the salt on the mucosa of the duodenum caused a complete local relaxation of the intestinal wall. It does not exert such an effect when the salt is administered by the mouth, that is, when it has to pass through the stomach before it reaches the intestines. The duodenal tube, however, apparently has reached an efficient, practical stage. I make, therefore, to test in jaundice and biliary colic, the local application of a 25 per cent solution of magnesium sulphate by means of the duodenal tube. It may relax the sphincter of the common duct and permit the ejection of bile, and, perhaps, even permit the removal of a calculus of moderate size wedged in the duct in front of the papilla of Vater. Twenty c. c. of the solution as a dose for an adult will bring no harm. The procedure could be developed into a practical useful method."

Meltzer further elucidated his theory of contrary innervation as applied to the gall-bladder and sphincter muscle of Oddi, that is, when the gall-bladder contracts, the sphincter muscle opens up, and *vice versa*.

This theory, with its contained possibilities, caught the attention of several clinicians, among the first being Dr. B. B. Vincent Lyon, of Philadelphia, who conducted numerous experiments along this line. In a recent paper he writes: "I have become more and more convinced of the practical ease with which both the normal and the pathologic biliary apparatus can be drained of its contents, with certain exceptions and within certain limitations. Further than this, I believe it possible to segregate and study bile

obtained from the duodenum, from the bile ducts, from the gall-bladder and from the liver. I do not mean to infer that this segregation of bile can be made so sharply that it can be said positively that any given sample is derived *exclusively* from the bile ducts or from the gall-bladder or from the liver, but segregated to the extent that it is possible to infer that the *larger amount* of the various types of bile recovered during a biliary tap is being drained from the ducts, from the gall-bladder or from the liver. If this much is admissible, I believe it possible by cytologic, cultural and chemical studies of these various portions of segregated bile to make certain inferential diagnostic deductions as to the condition of health—physiologic or otherwise—or disease within those ducts, that gall-bladder or that liver.”

Beyond the diagnostic possibilities embraced in this theory, there open up therapeutic possibilities most alluring to contemplate; and the results attained up to the present are encouraging.

In making duodenal taps, the method which we have followed, with certain modifications, adopted from time to time, is as follows:

The patient comes (best in the early morning hours) with an absolutely empty stomach. The mouth should be rinsed, either with plain water or a solution of potassium permanganate. A sterile duodenal tube, fitted with a metal tip of fairly good size, is passed into the stomach. At present we are using the Lyon tip, and find it quite satisfactory. After introducing the tube about twenty-four or twenty-six inches, the patient lies on the right side, and is made comfortable, for the seance sometimes lasts several hours. While waiting for the tube to enter the duodenum, warm water is frequently injected into the stomach for the double purpose of washing out that viscus and stimulating peristaltic action. The tube generally enters the duodenum in from fifteen minutes to an hour, though we have had one patient who required more time; and in several it has entered in eight or ten

minutes. The fluid running from or being ejected from the tube while it is in the stomach shows but little viscosity and is generally acid in reaction. When the tube enters the duodenum, this fluid assumes a decidedly viscid appearance, and is either neutral or alkaline in reaction. In a few instances we have noted yellow bile flowing before any magnesium sulphate was injected, but usually none appears until the solution of this salt is applied to the duodenal mucosa. Difficulty occasionally is encountered in entering the duodenum because of vagotonic states, or pylorospasm from such possible causes as a reflex from duodenal ulcer, cholecystitis or chronic appendicitis. This can be overcome by an injection of atropine sulphate or several days' use of benzyl benzoate. A definite and material stenosis of the pylorus would naturally prevent the entrance of the tube into the duodenum, though, fortunately, we have not as yet met with such an insurmountable obstacle.

Once sure that the tube has made a certain entrance into the duodenum, either a barrelful of air or a small amount of water is introduced from a 50 c. c. syringe so as to balloon out the duodenal walls from the metal-tipped tube, thereby preventing possible traumatism. The tube may then be connected with the first sterile aspirating bottle, and gentle aspiration begun.

In the fasting duodenal state, under physiologic conditions the sphincter of the common duct should be closed, and duodenal contents should be free from bile, with a grayish tinge, nearly transparent, quite viscid, and showing a small amount of flocculent sediment. In the presence of duodenitis, this sediment is greatly increased, and when much bile appears before the magnesium sulphate solution is injected, we may assume, according to both Meltzer and Lyon, the presence of some pathology of some group organs physiologically related to this intestinal zone.

We now introduce by means of a sterile 50 c. c. syringe from 50 to 100 c. c. of the 25

per cent solution of the above-mentioned salt, at about the body temperature or a little warmer. Gentle aspiration is begun, and usually in from two to ten minutes the bile begins to show, staining a light yellow the solution still in the duodenum. When the color deepens the first bottle is detached, and a second bottle brought into use. Gentle aspiration is continued, and it is sometimes necessary to make several injections of the solution before the desired results are attained.

Observation shows that the bile flows intermittently, especially after the bile in the ducts and in the gall-bladder has been drained, and is being collected as it is secreted from the liver capillaries. It would appear that first bile obtained is that present in the ducts—probably the common duct—and is generally about 10 to 20 c. c. The next and much darker bile, more viscid and turbid, we may reasonably assume comes from the gall-bladder itself. When the color of the bile begins to again become lighter, another bottle is connected, and we then obtain bile, probably directly from the liver, mixed with the duodenal secretion.

In a number of instances the different transitions of color, viscosity and turbidity have been graphically portrayed to us. In some, however, the change is not so noticeable.

The duodenal tap is generally terminated by douching out the duodenum with a warm solution of potassium permanganate, boric acid or liquor alkalinus andisepticus (N. F.).

Let us briefly discuss some of the diagnostic inferences to be drawn from the appearance of the aspirated fluid. In cholechochitis, the first bile is more viscid with much flaky mucus, is turbid, and may be a greenish yellow. It may contain pus cells, epithelial cells, and perhaps some red blood corpuscles.

In cholecystitis, without cholechochitis, the first bile obtained is normal appearing, but it soon changes to a grossly pathologic character, viscid, turbid, perhaps very dark, and

admixed with flaky or stringy mucus. The color may vary from a deep golden yellow to a light yellow, but always turbid. One case we have observed showed a frankly green color, but the turbidity was in evidence. Several other cases gave up bile of such a tarry consistency that aspiration was exceedingly slow.

As to the diagnosis of cholelithiasis, we have not arrived at any fixed conclusions yet. Lyon claims that in some of his cases of cholecystitis with gall-stones present, he noted that the bile contained a sediment that was "gritty" or sand-like in consistency, which was seen microscopically to be made of crystals of bile salts. We have observed a number of cases of evident chronic cholecystitis with some gritty sediment in the recovered bile, but, while gall-stones were strongly suspected, we did not feel justified in making a positive diagnosis from such data alone.

Regarding the practical therapeutic possibilities of this method of biliary drainage, they are certainly promising, but a sufficient time has not elapsed, nor has our experience been sufficiently comprehensive to permit us to speak with authority. To predicate an opinion as to the ultimate possibilities of non-surgical biliary drainage just now would be both unsafe and unwise. We feel, however, that it possesses real potentialities for good, and that the results so far attained seem to stamp it as worth while.

The indications embrace such disorders as chronic, recurring "bilious attacks," catarrhal jaundice, migraine, and infections of the gall-bladder, purulent or otherwise. To use the words of Dr. Lyon: "We are mechanically applying the surgical principles of free drainage for infected sacs, tubes and tissues, of free drainage for catarrhal states of inflammation of various grades, but without infection, of free drainage for gall-bladders that are atonic and contain static bile in which sooner or later there develop stones or a more serious pathologic condition, and while applying surgical principles, we are doing it non-

surgically, and avoiding certain surgical risks. Besides this, and even more important, we are preserving tissue which may possess a power of recovery of function beyond our present conception."

The method is not disagreeable to any extent, and even some markedly nervous patients have cooperated with us willingly and without seeming inconvenience. None of our cases have suffered any ill effects, either present or subsequent, and in a few instances they claimed to feel an almost immediate amelioration of some of the symptoms. We have made up to the present eighty-seven taps on twenty-two patients. The greatest number on a single individual has been eight taps.

We can affirm that in every one of our cases, in which three or more taps have been administered, there has been a clinical improvement in some instances quite striking. The malaise has lessened or disappeared, the skin has cleared up, the appetite and digestion have improved, in some the constipation has seemed relieved, and the general status has been changed for the better.

We feel encouraged with what has so far been accomplished—enough so to continue our efforts and observations.

We have not in this study endeavored to present any cytologic or bacteriological data, though we have some material at hand. This phase we hope to report on at a later date.

To briefly present the merits of this method of diagnosis and treatment is the object of this paper, and we hope to obtain the consideration of the profession in the effort to physiologically drain the gall-bladder as a means of diagnosis of biliary diseases, supplementing the usual clinical methods; as an alternative in types of gall-bladder or duct pathology, in which there is a doubt as to whether or not surgery should be invoked; and as a supplementary method of post-operatively continuing surgical principles of drainage in those cases in which previous surgical efforts have not been productive of ideal results.

A FATAL CASE OF PEMPHIGUS: WITH REMARKS ABOUT BULL- LOUS ERUPTIONS.*

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Lucile I., age 8, Elkton, Fla., referred by Doctor M. W. Seagears of St. Augustine, January 6, 1920.

The following history of illness was secured from the father: Some weeks previous, developed a few water blisters on the arms and neck, which were thought to be due to "poison" near the site of an abrasion. Never at any time more than a half dozen clear blisters. The child had always been healthy. Had no noticeable change in her health at this time, aside from a lack of her usual appetite, has not had any other skin disease or sickness.

Examination: Scattered over the extremities, neck and trunk were possibly a dozen small clear bullæ, none larger than one-fourth inch in diameter and the remains of a few ruptured lesions, some raw or excoriated, and a few covered with a thin crust. No scars of former lesions. The general condition of the little patient was good, a fairly well nourished child, eyes bright, and some color to her cheeks. A specimen of her urine revealed nothing abnormal. There was no elevation of temperature. There were no symptoms of itching or pain in the lesions, though at the time of the development of the bullæ there was a slight burning sensation. The bullæ would appear suddenly from the white skin, with no areola of redness.

A diagnosis of bullous dermatitis was made with a question mark as to pemphigus. In the absence of itching and grouping herpetiforme dermatitis (Duhring's disease) was excluded. Bullous impetigo was excluded both by the clinical symptoms and a microscopical examination of some of the clear serum from one of the unbroken bullæ. There was no areola of redness around any of the lesions and no characteristic crusting

*Read before the Duval County Medical Society, November, 1920.

of impetigo. Bullous type of erythema multiforme was also excluded as none of the usual erythematous lesions were present.

The following treatment was instituted: A daily warm soda bath, followed by an application of simple calamine-oxide zinc lotion, the unruptured bullæ ordered opened with a sterile needle, and two grains of cacodylate of soda, two or three times a week. A favorable prognosis was given. January 20th, two weeks since the first visit, the patient was brought to the office by the father. At this visit a marked change in the general condition of the little patient was noted. The lesions were more frequently appearing and they were slower in drying with the lotion. The patient had a temperature of 100 F., some loss in weight, no appetite and the occurrence of bullæ in the buccal cavity made the case one of more severity. A diagnosis of pemphigus was clearly correct and the outlook to me at this time was doubtful, though by no means hopeless. The father was advised to place the child in the hospital at St. Augustine. Ten days later in consultation with Doctor Seagears, the patient showed the following condition: The entire body, face and extremities with very few areas of skin free from either new bullæ or the excoriations of former lesions, with the addition of pustulations, new lesions, were cropping up in the parts of the skin just recovering from former lesions. Temperature nightly 100-103 F., for awhile the morning temperature was normal or subnormal. Albumen in the urine, swollen feet, and the heart action weak and irregular. Bullæ were found in the mouth which rapidly ruptured and bled easily. Bowel movements later showed blood. Treatment now consisted of daily suspension baths of boric acid followed after careful drying with talc powder-stearate zinc-boric acid, the internal treatment and hypodermic medication consisting of stimulants and tonics. Owing to the rapid course of the disease autogenous vaccine were not tried, but a mixed stock vaccine of staphylococci and streptococci was given. The little patient

died ten days after going to the hospital and the sixth week after being seen by the writer.

In connection with the report of this fatal case of pemphigus, attention is called to the history of a starting point, *i. e.*, the arm, for unquestionably some poison (bacteria) must have gained entrance to the system. Next, the apparent mildness of the disease at the first visit and the rapidity of the development of unfavorable symptoms, the occurrence of lesions in the mucus membrane, fever and sero-pus in the old bullæ, nephritis, and the progressive nature of the eruption with the final collapse.

The cause of pemphigus is not definitely known, the general opinion is that some unknown bacteria is the active cause of the disease. The streptococci have been considered, but no definite proof has been obtained that these organisms are the cause of pemphigus.

Mention is made of the four clinical varieties of pemphigus, acute, chronic, foliaceous and vegetans. The case just reviewed is of the acute variety. There is another clinical type of so-called pemphigus virginium, in which a few pemphigoid lesions are developed on the skin of young girls, of the so-called chloroid type; this form of pemphigus is benign and usually responds to tonic treatment. Fortunately pemphigus is a rare disease. The writer has seen only six cases of acute pemphigus in fourteen years of hospital and private practice. All of these cases terminated fatally in from six weeks to four months. Also only two cases of pemphigus foliaceous and one of the vegetans type; the two foliaceous type were chronic cases and were seen in hospitals, one had his disease for three years, and the other one year. I do not know how they terminated. I do know that the eruption will at times clear up and then return without any warning. Unquestionably most cases of so-called pemphigus are nothing more than bullous impetigo, the streptococcus impetigo, especially is this true of the bullous eruption of children, spoken of as pemphigus-neonitum. Some-

times the bullous type of syphilis in infants is mistaken for pemphigus, and in later life the lesions of erythema multiforme bullosa are mistaken for pemphigus.

At this point a few words about the so-called bullous dermatitis. This term is used by some dermatologists to cover a bullous eruption that has clinical features of both pemphigus and herpetiforme dermatitis. For instance the writer presented to the County Medical Society, several years ago, a very interesting case of bullous dermatitis following vaccination. This young boy had had for several years a recurring crop of bullæ, the lesions clinically pemphigus, the grouping characteristic of herpetiforme dermatitis. Similar cases to this one have been from time to time reported in medical literature as being due to some poison introduced into the system through vaccination. I had the opportunity of seeing another case as the preceding, in a soldier at Camp Johnson during demobilization. He gave a history of having had a recurrent bullous eruption on the arm and later on the body, occurring a few weeks after vaccination. This patient when seen by me was mustered out of the service and on his way to Boston. I referred him to Dr. J. T. Bowen, of Boston, who has given us several reports of this unusual condition. The bullous type of impetigo is no doubt familiar to all of you, especially the type that we see so often in Florida during the hot months of summer, that is the occurrence of the vesicular lesions under the arm, genito-crura region and under the breasts of women, and at times covering the body. Multiforme erythema will occasionally show a bullous type, usually though there are the typical erythematous lesions present and one is not apt to have any difficulty in making a diagnosis, especially with occurrence of the so-called erythema-iris or the herpes-iris. Vesicular or bullous syphioderm is at times met, a diagnosis as a rule is not difficult to make, for as in dermatitis herpetiformis there are usually present different types of lesions and always some of the constitutional symptoms of syphilis.

THE INTERNIST AND SURGEON IN RELATION TO ACUTE ABDOM- INAL DISEASES.

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The term "acute abdomen" has been used by Deaver¹, Eisendrath² and others to designate this rather extensive field of work.

Most of the cases of acute abdominal diseases are seen by the internist or general practitioner first, hence it is essential he be versed in the diagnosis of such lesions.

Very often the life of the patient depends on an early diagnosis and prompt surgical work. Delay, uncertain or incorrect diagnosis frequently mean serious complications or death.

Every physician, when possible, should see the results of his diagnosis on the operating table when an operation is performed.

A surgical demonstration on the living subject is far more beneficial than a post-mortem diagnosis.

Far better make a provisional diagnosis that demands surgical interference than wait for an accurate diagnosis on a dead subject.

A post-mortem diagnosis is based on dead pathology, a surgical diagnosis is based on living pathology.

In making a diagnosis in acute abdominal diseases the previous history and the present condition of the patient must be considered.

Perforations, strangulations, traumatisms, exacerbations of chronic lesions, and purely acute initial lesions must be considered in arriving at a correct diagnosis.

Perforations and strangulations often produce acute conditions in chronic lesions. Perforations may follow ulcerations in the duodenum, stomach, in diseases of the appendix or gall-bladder, and in the wake of typhoid fever.

Previous history is important in these cases.

Acute conditions may arise from strangulation in all forms of hernia, external or internal, from twisted pedicle in ovarian cysts, volvulus, intussusception, constricting bands, diverticuli, and from congenital de-

fects leaving openings for incarceration of abdominal viscera which must not be lost sight of in making a differential diagnosis.

Traumatisms often give more direct evidence as to the cause of the acute condition, but the exact injury to internal viscera frequently cannot be ascertained without opening the abdomen for proper investigation.

In penetrating, stab, or gunshot wounds of the abdomen, the surgeon should be called at once, and if the wound extends into the abdominal cavity, the abdomen should be opened under aseptic or antiseptic precautions in order to arrive at a correct diagnosis and institute proper treatment.

To delay, every hour, especially after twelve to twenty-four hours, lessens the patient's chances for recovery if hollow viscera have been perforated and septic material extravasated.

After twenty-four hours surgical work for a diagnosis is not justifiable, but in some cases an opening for drainage may be justified.

Crile³, in writing on war surgery, states: "The length of time between the receipt of the wound and arrival at a hospital was a vital factor. After the tenth hour the prognosis became progressively worse until the twentieth hour, when, as a rule, the established infection made operative measures inadvisable."

Acute exacerbations of chronic lesions call for consideration such as of the appendix, ulcers of the stomach or duodenum, disease of the gall-bladder, gall-stones, and at times pancreatitis should be recognized and differentiated.

In considering the primary acute conditions, the most obscure are mesenteric thrombosis, infarcts of the spleen, internal strangulation due to a diverticulum or congenital defects or to a twisted ovarian pedicle.

Acute appendicitis, gall-stone colic, cholecystitis, renal colic, and volvulus are more common and fortunately often more easily recognized.

It is important in this connection to remember that pneumonia, diaphragmatic pleurisy

and gastric crises of tabes may simulate appendicitis and acute lesions in the abdomen.

The classic symptoms of acute appendicitis given by Murphy⁴, the master clinical diagnostician, have done much to clear up the diagnosis of appendicitis: "It is pain, nausea, and vomiting, local sensitiveness, elevation of temperature and an increase in the number of leukocytes. That is the uniform order in which the symptoms occur. Nausea never precedes pain, elevation of temperature never precedes pain."

In some cases the pain may not at first be in the region of the appendix, but later localizes at that point.

When pain is not located at the appendix, we have a cardinal symptom that rarely fails. Pressure over the appendix will relieve tenderness in the other part of the abdomen at the seat of pain. Make pressure over the seat of pain and you elicit marked tenderness, then make pressure over the seat of the appendix until you elicit tenderness. Keep up this pressure over the appendix and at the same time make pressure again over the seat of the pain and there will be lessened tenderness if the appendix is involved, and the cause of the pain and tenderness.

Pressure over the right Morris point is also a symptom of value in diagnosing disease of the appendix or right adnexia of uterus.

In acute bowel obstruction we have increased peristalsis above the obstruction and elevation of temperature comes late if at all, pulse rate prostration, and regurgitation gradually increase, later fecal vomiting, while in appendicitis we have elevation of pulse and elevation of temperature earlier with decreased peristalsis. Nature is trying to save the life of the patient by lessening peristalsis to prevent the spreading of infection and often walls off the appendix before rupture. This is the principle on which the Ochsner treatment of appendicitis is based when operation is not performed in the early stage or can not be done.

Every page written on the diagnosis or treatment of appendicitis should have written

across its face in *large red letters*: DO NOT GIVE CATHARTICS, DO NOT GIVE FOOD. CATHARTICS AND FOOD INCREASE PERISTALSIS, SPREAD INFECTION, PRODUCE COMPLICATIONS AND DEATH OFTEN IN SPITE OF THE SURGEON.

The only variation from this rule is at the very beginning of the attack when the stomach and bowels should be cleared out, especially if the patient has just eaten a hearty meal or the bowels have not moved for some time.

Best clear out with large doses of oil and enemata, do not give drastic cathartics; also use the stomach tube if the stomach is full of undigested food or vomiting continues. After this suspend all cathartics and food until the patient is out of danger.

Warbasse⁵ states: "Food and cathartics should not be given until patient is free from pain four days."

After the first clearing out of the bowels at the very beginning of the attack the giving of cathartics and food have killed more patients than surgery has saved.

Bowel obstruction usually gives a different picture: severe pain, increased peristalsis, persistent and later fecal vomiting, often palpable tumor, meteorism, increasing and weakened pulse rate, no fever at first, may come later if infection or inflammation, in latter stage rapid pulse and collapse.

Cholecystitis, gall-stone colic, renal colic, especially in a movable right kidney or stone in the right ureter, require differentiation at times.

Location of the pain and tenderness, palpation of the enlargement and its movability, presence or absence of jaundice, presence or absence of fever, presence of blood in the urine, suddenness of the onset of pain and previous history all aid in a diagnosis.

A stone in the right ureter may be very easily mistaken for trouble with the appendix unless one is careful in searching the urine, using the ureteral catheter or X-ray.

Roberts⁶ states: "Eighty per cent of gall-bladder pathology and stones occur in women and twenty per cent in men." That "one-fourth of all peritonitis is due to appendicitis."

Warbasse⁷ says: "Cholecystitis and cholangitis cause pancreatitis; pancreatitis aggravates cholecystitis and cholangitis; drainage of the ducts through the gall-bladder destroys the vicious circle."

Perforation from ulcer of the duodenum, stomach, gall-bladder, appendix, or the intestine from typhoid fever, stab or gunshot wounds furnishes quite a field for differential diagnosis.

The contents escaping from the duodenum or stomach are more or less sterile, but not so with the gall-bladder, intestines or appendix, and especially the large intestine. Early diagnosis in these cases is important for the best interest of the patient. Delay, unless the material is walled off and localized, means a serious risk to the patient.

Deaver⁸ states: "All perforative inflammations tend to generalize. Appendicular inflammations have a strong natural tendency to localize and so do cholecystic and pelvic inflammations."

In the later stages of typhoid fever sudden pain, marked tenderness, rigidity of muscles, rapid pulse, and extreme prostration give a picture of perforation. In perforation of the appendix, if the point is walled off which it frequently is, the infection is localized and the time for operation can in a measure be selected, but if not walled off then we will have a general peritonitis and profound sepsis which demands immediate operation.

All such cases should be put in Fowler's position at once, kept in that position until operation, during transit to the hospital and remain in that position after operation until out of danger. The diagnosis of such a condition demands immediate operation, free drainage, Fowler position and proctoclysis.

It is impossible to present this subject in detail in one paper, but from this brief condensed survey it is evident that acute abdominal diseases are of vast importance to the internist and surgeon. Professionally, each has his duty and responsibility which he can not evade and do justice to his patients and the profession. The internist is responsible in the majority of cases for an early diagnosis

and prompt action. The surgeon when called must be prepared for prompt action when needed or to hold surgery in abeyance until such time as will conserve the life of the patient or get the best ultimate results for physiological functions.

Much work and investigation has yet to be done before the diagnosis and treatment of acute abdominal diseases and lesions are standardized.

We have at our command at this time a vast amount of information on this subject which should be more widely disseminated and more frequently discussed where the internist and the surgeon meet.

1. Surg. Gynec. and Obs., January, 1920.
2. Surgical Clinics, Vol. II, No. 4, August, 1918.
3. Amer. Med. Assoc. Jour., August, 1919
4. Murphy's Surg. Clinics, August, 1912.
5. Surgical Treatment, Warbasse, Vol. III.
6. Southern Medical Jour., November, 1919.
7. Ibid., 5, page 115.
8. Ibid., 1, page 34.

THE NURSE IN RELATION TO CHILD CONSERVATION.*

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"The attitude of a nation toward child welfare will soon become the test of its civilization."—*Herbert Hoover.*

The work of a public health nurse in child conservation finds its Alpha and Omega in that of the physician and dentist. While all three work for the same general object, there are certain differences and difficulties which present themselves to the nurse that the two other professions do not encounter.

It is universally recognized that a physician or a dentist has a definite health work to do, are authorities, so to speak. The work of a nurse exists to make effective the aims and purposes of the other two. She reaches these through quite different channels, and must so approach the individual and the families of a territory as to be able to interpret to these persons the objects which are desired to be reached in a health program.

The nurse must recognize that her services in the field of public health are new, that while she may be misunderstood at times, yet she has a message to deliver which must have a twofold purpose, that of amplifying the proposed work of the physician and the dentist by explaining the necessity for it to the people it is desired to serve and at the same time impressing these people with their advantage in securing the service.

While the trained professional man has the advantage over the nurse in that his technical services are immediately understood, on the other hand such services are automatically associated with the phase of supply and demand and carry with them an atmosphere of possible financial advantages to the practitioner. It is apparent to those using the services of a public health nurse that not even in the most indirect way does her service redound to her individual financial interest. In other words, to families who are urged to consult a physician or a dentist because of defects noted there is often a subconscious feeling that "Of course, he wants the fee." This feeling does not exist in the case of a nurse who is known to be employed by a given agency and who does not secure personal fees. If fees are paid for service, they are paid direct to the agency. On purely utilitarian grounds, the nurse has an entree into the home which may be denied the doctor, and for this reason her work may prove of special value to a health program from an educational, if from no other viewpoint.

All agents are necessary to complete success, but the nurse can make a very great contribution to child welfare and health. Fortunately for the children of today, science has united in deciding that no concerted effort is too great, no technical knowledge too minute to be used in determining the need of individual children and then of filling this need perfectly as is humanly possible. On the other hand, in our present social system, no agency, however perfect, can possibly be applied to the individual child without the consent and the cooperation of the parents or guardians of the child, and one of the most important contributions that

*Read before the Florida Midland Medical Society, at Orlando, October 13, 1920.

a nurse may make to health work, is to secure a full understanding and acceptance of them by the parents, and more particularly by the mothers, of children. Here the nurse is aided by the divine instinct of parental love. The nurse finds one of the most difficult problems solved by calculating wisely on this emotion and enters many homes as a welcome and honored guest because she comes to help the children when otherwise she might not be permitted to enter at all.

The school room, therefore, may be considered as the keynote to the situation in a new territory. Let us suppose this potent stronghold has also been selected by the county health officers and by the physicians and dentists and specialists of a given community for a joint point of attack, and sweeping announcement has been made that the children in the town or county are each one to be subjected to a physical examination. The public health nurse might give a series of short talks to teachers in which certain facts might become known, such, for instance, as that of the 22,000,000 school children in the United States at least 14,000,000 have been found to be defective. That no doubt a proportion of these children are found in the schools of the county in question, and that in order to determine the degree of physical inefficiency presented the examination should be made. The examination may be conducted with little or no interruption of the regular school work; consideration should always be given to the work of the school-day by the health officer or physician directing the school examinations. The nurse finds her educational opportunity in the schools. Teachers are usually keen to see the need of health education, but are especially anxious to have their pupils make a good scholastic showing, and if they should be slow in co-operation in regard to the physical examinations the nurse can explain the effect on a child's condition of malnutrition, adenoids, diseased tonsils, defective vision, hearing, lung or heart diseases, hookworm, malaria, etc. The large percentages of such defects as have been discovered in the 22,000,000

school children will impress the teacher anew with the possibility of her pupils being among the defective number and of the futility of her own work when matched against physical handicaps. When the examinations are regularly established, the public health nurse is supplied with standard cards on which defects are marked. More physical examinations and determinations of defects do not promote health until defects are corrected, and when a public health nurse follows up the cases a greater improvement in the health of the school children has been noted. The following figures are indications of the nurse's contribution. The percentages are based on two groups of 1,358 and 1,780 children in Philadelphia schools found with physical defects:

1. Recommendations of doctors acted upon:

With nurse's aid	89 per cent
Without nurse's aid	24 per cent
2. Treatment obtained for teeth:

With nurse's aid	92 per cent
Without nurse's aid	20 per cent
3. Treatment obtained for eyes:

With nurse's aid	80 per cent
Without nurse's aid	26 per cent
4. Treatment obtained for adenoids:

With nurse's aid	73 per cent
Without nurse's aid	14 per cent
5. Treatment obtained for tonsils:

With nurse's aid	65 per cent
Without nurse's aid	18 per cent

The value of a health campaign for children beginning with the school has been touched on first because it presents the most tangible angle at which a nurse can touch the work of the health officer and the local physician, and by which the entrance into the home may be made in the most natural way.

This having once been accomplished, the pathway is clearly before the nurse, and she may go safely forward toward a general health campaign for children conducted this time from the stronghold of the family and reinforced by the ammunition of parental love and interest for the school child as well as the extension of this same emotion to the other children in the same family, or she may use this entrance into one home as a warrant for an introduction into the homes of the neighborhood in which there are young children of pre-school age or in which there are infants under one year, and also in which

there are mothers treading the perilous pathway before the advent of their babies into the world.

Childhealth depends so largely on parental health that the prenatal care of the mother may be considered the foundation of future health for the child. The nurse will need all the tact, influence, knowledge and persuasive power at her command. The natural reticence of women who desist or refuse altogether to report their cases to physicians sometimes are slow to tell even the nurse. Our government, be it ever so paternalistic, has not yet required that the expectant mother shall register her hopes and her prospects with the state. Yet, in the world-wide campaign for a better race, this step would not be too drastic considering the lack of knowledge which hundreds of thousands of mothers show during a time of their lives when they should be best informed as to the most hygienic rules which secure for themselves and their offspring the only possible security for future health, usefulness and even for life itself.

The world needs citizens who are physically efficient; it needs women who are strong and well and able to bear healthy children. In our widespread campaign to protect our citizens from the 630,000 needless deaths from preventable diseases which occur in a single year, we have not yet given to childbearing the consideration which it demands, and while our death rate from tuberculosis has been reduced one-third, from typhoid fever and diphtheria have been cut exactly in half and from smallpox has been reduced from 10 per cent of the population of the world to one-half of one per cent, that from the so-called "natural function" of childbearing has been unchanged for a period of some twenty years. During the year 1919 it has been shown from carefully prepared statistics that five women out of every thousand die from some cause connected with childbearing; this is equal to one woman out of 185 who subjects herself to this risk. This of course, means that our population has been reduced by just this much of this most

valuable element, while in considering the deaths of children it is alarming to remember that forty-five babies die out of every thousand; that one out of every twenty-two born are born dead; that forty out of those born alive die before they are one month old in cases where no skilled care is given to the mother before or at the time of birth. On the other hand, when such care is given the further statistics show that only two women instead of five die out of every thousand; that only twelve babies instead of forty-five are stillborn and that only ten instead of forty out of every thousand die under one month.

These figures are to the good public nurse a battle cry urging her on to service. Going into the home, seeing a pregnant woman, the whole picture of dire possibilities presents itself to her and at once she finds work for her busy hands to do and for active brain to outline and direct. Doctors there may be close at hand; how many women report to these doctors monthly during their period of pregnancy? How many have any idea that this should be done? How many have the proper care at the time of birth? The figures just given show only too few, and therefore reducing the number of deaths from causes relating to childbearing and bringing women within the range of competent medical care.

The Metropolitan Life Insurance Company has gathered some valuable statistics on the subject, and I quote the following from a bulletin of this company's issued by Dr. Lee K. Frankel, Third Vice-President of the company. Dr. Frankel's bulletin says:

"The life conservation work of the company reaches more particularly women and children. If our assumption is correct, we should expect to find a larger mortality reduction among females than among males and, secondly, among children than among adults. That this is actually so is shown by the following gains in mortality between 1911 and 1917. The reduction in the death rate among white males was 6.6 per cent. Among white females the reduction was 12.1 per cent. At every age the reduction was much more marked among females than

among males. In both sexes the reduction was very striking for all ages under one year. Between the ages of 25 and 34, the child-bearing period, female industrial policy-holders showed a reduction in the death rate of 20.5 per cent, whereas in the registration area the reduction was only 3.8 per cent. The saving was five times greater in the one group than in the other. Such a difference cannot be explained by chance, but rather by the very effective work of the Nursing Service which has concentrated its efforts upon the women at childbearing ages."

The natural confidence of woman in woman gives the nurse an advantage in bringing about the needed care for the pregnant woman more effectually than can the health officer or the physician. Such care can only be given by medical skill, but the nurse can educate the mother to her need of medical care and report conditions. This the prospective patient is willing to accept usually when she could not be persuaded to go to a doctor in the beginning. Having been of service to a mother before the birth of her baby, the nurse naturally is the one consulted to give advice to the mother for the care of that baby after it comes into the world. The bathing of the baby, the advantages of breast-feeding, the directing of the preparation of artificial food where the doctor indicates its necessity, all fall within the jurisdiction of the nurse, and by her untiring energy, interest and understanding, many small lives have been launched on the treacherous sea of life with an added measure of certainty that in time the goal of adult health may be reached.

The nurse understands the value of preventive measures; she realizes the truth of the maxim that an "ounce of prevention is worth a pound of cure," and in order to procure this illusive "ounce" she works as hard to keep well babies well as she does to help sick babies get well. It would be a wonderful health measure if every county health officer, every physician and public health nurse could employ the method once used by the mayor of Huddlestone, England,

who following the example set in baby-saving which was begun in France shortly after the Franco-Prussian War, when it was so imperative to preserve lives for the nation, offered a prize of one pound sterling to every mother who brought to his office a baby on its first birthday. In order to insure some applicants for his prize, Mayor Huddlestone established a system very similar to that of the Public Health Nursing system used today, and by this plan mothers and babies were visited in their own homes at regular intervals, and so carefully were the little lives guarded and conserved that at the end of the first year the death rate was reduced in that town from 139 per 1,000 to only 44 per 1,000, which has not been materially improved by our modern methods of baby saving. But the plan attracted so much attention that it resulted in making all births in that town reportable to the health authorities in order that local laws might be made appointing a full staff of nurses to do this sole work regularly.

From this fact, developed more than forty years ago, and from further facts steadily accumulated in this country since the New York State Board of Health established a Baby Welfare Section in 1908 to the present day, it has been amply demonstrated that the lives of babies might be saved by judicious care, proper feeding, proper care of the mothers before births and by simple measures of hygiene which outrank all measures of actual medication in the influence had on the lives of babies. Hence it may be said with final authority that *keeping babies well* is one of the most important ways in which a public health nurse may cooperate with local health authorities, for with the baby kept well and given a fair start in life, the child of pre-school and of school age may safely be considered as equipped at least with a solid foundation of physical fitness. Structure on this foundation becomes a part of the nurse's work. She stands shoulder to shoulder with the health officer and the pediatric clinics in conducting nutrition for mal-nourished children; in establishing baby public centers

for well babies and baby clinics for sick babies. If a public health nurse has the highest ideals of service, she will enter freely upon any program for promoting public welfare, but, being a woman, she will respond quickest to the immemorial call of motherhood and lend herself with peculiar enthusiasm to every movement which tends to the protection of infancy, the conservation of maternity and to the positive promotion of child welfare.

THE VACCINE TREATMENT OF NEPHRITIS.

G. H. SHERMAN, M. D.,
Detroit, Mich.

The bacteriology of the urine in health and disease has been extensively studied. To arrive at a positive conclusion whether or not the urine is sterile in health is surrounded with some difficulty because staphylococci are usually present in the urethra. So, even when a specimen is collected by catheterization, there is always a chance of urethral contamination, but the number of organisms from such a source are always small, and when a considerable number of germs are found in the urine it is safe to assume that the organisms are present in the urine.

Some extensive work on the bacteriology of urine was done by Drs. George F. and Gladys R. Dick who, to avoid contamination, collected the urine by catheterizing the ureters. Culture of 2 c. c. of catheterized urine were made in deep tubes of dextrose agar; aerobic and anaerobic cultures on blood ascites agar were made from the sediment of 15 c. c. of centrifuged urine.

A study of their work shows that the urine in health is for all practical purpose sterile, only one colony of pseudo-diphtheria bacillus being found in case one and eleven colonies of staphylococcus in another case. It will be observed that the streptococcus is the most common known pathogenic organism that was found in both the acute and chronic nephritis. They also found that in cases of coccus infections, organisms identical to those present in the infected focus may also

be found in the urine without the presence of albumin, casts or other indications of kidney disease. This is in accord with the findings of other investigators and would indicate that the kidney is capable of eliminating live pathogenic organisms from the blood as it passes through the kidney.

Dodge reports cases of focal infections treated with vaccines prepared from organisms isolated from the urine and contends that the kidneys eliminate organisms that gain entrance to the circulation.

The frequency with which streptococci are found in the urine in scarlet fever, pneumococci in pneumonia, and micro-organisms in typhoid, and other acute infections without albuminuria or other indications of kidney involvement is good evidence that germs may pass through the kidney without injuring it. The frequency with which nephritis follows scarlet fever shows, however, that streptococci may become active pathogenic agents in kidney inflammations. Rosenow (*Jour. A. M. A.*), by inoculating rabbits intravenously with streptococci isolated from kidneys, found that 75 per cent of the rabbits thus inoculated showed kidney infection.

Two concepts prevail concerning the cause of kidney inflammation: (a) that toxic materials passing through the kidney while being eliminated irritate the kidney structure and lead to inflammation; (b) that kidney inflammation is due to a direct infection of the kidney substance. That irritating substances eliminated by the kidneys do cause kidney inflammation is well illustrated in cases of bichloride of mercury poisoning, etc., but we find that these cases recover rapidly if the specific poison is disposed of. In case a nephritis develops during the course of an acute infection, it is believed by some that the kidney inflammation is similarly due to the elimination of toxic materials, but this contention does not appear well grounded because in the vast majority of acute toxic infections no evidence of kidney inflammation develops. From our present knowledge of inflammatory processes we must conclude that an active nephritis, except when due to

some specific poison, must be regarded as due to infection.

The fact that so many cases of nephritis date back to the various acute infections is strong evidence that the kidney infection is a sequence to such an infection. It is not uncommon to have cases of nephritis follow tonsillitis or a "cold," and in such cases we must conclude that the infecting organisms responsible for the primary infection developed a metastasis in the kidney. This would emphasize the importance of therapeutic immunization with vaccines in the treatment of colds and other minor infections. By this method sufficient immunity is developed during the primary infection to avoid the concurrent or subsequent kidney involvement. At least this is our experience, to our knowledge no case of nephritis having developed in cases where vaccines were employed for the treatment of the primary infection. Since the streptococcus is always a primary infecting agent or a complicating factor in infective processes that lead to the kidney infection, and since careful bacterial examinations of the urine in cases of nephritis uniformly show the presence of streptococci, it is necessary to regard all cases of nephritis as being fundamentally due to streptococcus infection. Other organisms are also frequently found in the urine of nephritic cases, but these may be regarded as secondary invaders. So, in the selection of a vaccine for the treatment of nephritis, it is essential that the streptococcus should be an important constituent, and that the other organisms usually found as secondary invaders should also be contained in the vaccine. The combination most generally employed contains streptococci, pneumococci, staphylococci, and colon bacilli.

In the treatment of nephritis a clear distinction must be made between extensive acute and chronic varieties. In acute nephritis, the inflammation of the kidney is often so intense that the entire function of the organ is suspended. This makes the infection a very serious proposition, not so much from the amount of tissue involved and the

amount of toxic materials evolved from the infected tissue, as from the fact that a most important organ of the body has been deprived of its ability to function. In a case of erysipelas, for example, the streptococcus will involve much more tissue than in a case of nephritis, but in this instance, the tissues involved are not essential toward sustaining life while the infection is running its course as is the case in nephritis. This makes it doubly important in the case of kidney infection to get rid of the inflammation as soon as possible, before enough of the waste products which the kidneys otherwise eliminate, have time to accumulate in the body to cause death by uremic poisoning. The earlier in the course of the disease, immunity can be established, the better are the chances for recovery. This necessitates the administration of a proper combined stock vaccine at once. To delay vaccine treatment in such a case until a careful bacterial examination of the urine can be made to determine the infecting organism might be responsible for a fatal termination. The infection being acute, probably associated with considerable fever, a large dose 1.0 mil. repeated at daily intervals for two or four injections is indicated, then at two- to four-day intervals if the patient progresses favorably. It is very important that the vaccine should be employed early, before extensive uremic poisoning has set in, because tissues are much more responsive to the stimulating influence of the vaccines for antibody formation before the vitality of the patient has become exhausted. Meantime, elimination by catharsis, hot packs, drug-induced perspiration should be persistently carried out to sustain the life of the patient until immunity with a resulting elimination of the kidney inflammation becomes established.

In the less acute cases where the kidneys continue to function fairly well, these adjunct measures to vaccine treatment are not so important. As a rule, they progress favorably under the vaccine treatment. In this class of cases, treatment should be started by giving 0.2 mil. and gradually increasing the dose to 1.0 mil., making inoculations at three- to five-

day intervals, depending on the reactions and progress of the patient. Cases of nephritis of pregnancy that are not too far advanced would come under this class.

Chronic cases of nephritis progress under the vaccine treatment in direct proportion to the permanent damage that the kidneys have sustained before therapeutic immunization was instituted. Kidneys that have become contracted as a result of long-continued inflammation cannot be expected to be restored to function normally. If, however, sufficient kidney structure remains which can function normally after the infection is eliminated, to eliminate the waste products of the body metabolism, health can be restored. It is impossible to know in advance just how much of the kidney function can be restored to health. For this reason, no case of nephritis should be abandoned until the vaccine method has been given a thorough trial.

The following case serves as a good illustration:

Mrs. S., aged 60, had been sick with nephritis for eight months. Six months of this time she had received treatment from competent regular physicians and two months of hydropathic treatment at a sanitarium consisting of sweats and baths, being restricted at the same time to an absolute vegetarian diet. She steadily grew worse and was sent home as a hopeless case. When first seen she was very dropsical, the whole body being swollen and only one-half pint of urine was passed in twenty-four hours. The first consideration was to relieve the dropsical condition for which pilocarpin was given to procure free perspiration and elaterium to produce copious watery stools. The next day a dose of streptococcus-colon bacillus combination vaccine was given and a sample of urine was procured under aseptic precautions for bacterial analysis. There was not much sediment, but colon bacilli were found in abundance. On boiling and precipitation with nitric acid, urine showed that one-half its volume was albumen. Her improvement after the first dose of vaccine was so marked that it was continued at five-day intervals

for six weeks when she was feeling quite well, passing a normal amount of urine and the dropsical condition was almost entirely gone. The urine, however, still showed small amounts of albumen, so the treatment was continued regularly for a year, during which large and small doses at long and short intervals were tried out, but the albumen still persisted in small quantities. Otherwise she felt entirely well. She received occasional inoculations of vaccine after that for several years, but was lost track of after that. Eight years later, she called for treatment again on account of some swelling of the feet which had been developing for a few days. She said that she had felt entirely well up to the time her feet began to swell. Urine examination showed a large amount of albumen likely due to a new infection of the kidney. A combined stock vaccine containing streptococcus, pneumococcus, staphylococcus, colon bacillus, was given at once. Five days later she called again when the swelling of her legs was almost entirely gone, but there was still considerable albumen in the urine. The vaccine was repeated at weekly intervals, and in six weeks' time the urine was almost entirely free from albumen. There is still some trace of albumen in her urine, but clinically she is entirely well.

In the treatment of chronic nephritis, the same streptococcus, pneumococcus, staphylococcus, colon bacillus, combined vaccine is employed that is used in the acute cases. The dosage and management of the case, however, is different. Following the rule of treating chronic conditions, treatment is started with the usual small dose 0.2 mil. and administered at long intervals, five to seven days apart. The dose is gradually increased to 1.0 mil. or more, but should not be increased so rapidly that marked reactions follow the infection. Treatment should be continued until the urine clears up or until it is evident that the damage cannot be repaired. Treatment should be continued for at least six months before considering the case beyond improvement.

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Next Meeting—Pensacola—May 10, 11, 1921

A COMPOSITE MEDICAL EXAMINING BOARD.

The time has never been more propitious than the present to secure adequate medical legislation controlling the right to practice the healing art in the state of Florida. Governor Hardee in his message stated: "We should have a more effective system of examination and licensing of medical practitioners. This not only for the protection of the high and honorable members of a great profession, * * * but the protection of the public against the unprepared and un-informed practitioner. * * * It is for the protection of the people primarily which causes me to invite your attention to the necessity for a more effective system, looking to the issuance of licenses to practice."

This hits the nail squarely on the head. Heretofore bills presented in our legislature for the control of license to practice medicine and surgery, and the arguments put forth in their support have possibly leaned too much toward the protection of the profession and not enough toward the protection of the people; at any rate this is the view that many of our legislators have entertained. However ardent we may be in the support of the regular school of medicine, we have to recognize that other schools have equal legal rights in all of the states of the Union. Some of the cults have no right to exist—with proper educational requirements as a proviso for legal registration, they will very soon cease to do so. A composite board of medical examiners including the schools of homeopathy—the eclectic with that of the regular school—should have the hearty support of the entire profession.

There is no need for THE JOURNAL to dwell on the fact that under existing laws Florida is the dumping ground for the quacks and men of low professional qualifications. With the Chief Executive of the state urging the passage of a law that will correct the existing evil, it behooves every member of the profession to exert himself in accomplish-

ing this most desired end. Petty differences should be relegated to the rear. If we cannot secure the passage of a bill that to our individual mind removes all existing evils, we should be satisfied with one that will result in at least an improvement over present conditions. The Committee on Legislation and Public Policy of the Florida Medical Association has not furnished THE JOURNAL with a copy of the bill to be introduced during the present session of the legislature, but we have no doubt that the legislative experience of Chairman Joseph N. Fogarty, together with that of Doctor W. L. Hughlett, a member of the committee, combined with the experience of Doctor Wm. M. Rowlett, Secretary of the Regular Board of Examiners, and Past-President E. W. Warren, also members of the committee, has resulted in the preparation of a practical bill—one that will protect the people and one that will afford protection to the profession.

THE JOURNAL urges every member of the Florida Medical Association to interest himself in securing the passage of this bill, at least to the point of writing a personal letter to his representative and senator in Tallahassee.

G. E. H.

THE PENSACOLA MEETING.

The forty-eighth annual meeting of the Florida Medical Association will be held at Pensacola on May 10th and 11th, the second annual meeting of the Florida Railway Surgeons on the day previous. Preliminary programs of both of these meetings are published elsewhere in this issue. The sudden illness and untimely death of Doctor Murray W. Seagears, Chairman of the Committee on Scientific Work and President of the Florida Railway Surgeons' Association, interfered with the preparation of both programs, so that neither are in any sense completed. Members desirous of being placed on the Association program should address Doctor Gerry R. Holden, Jacksonville; Doctor J. W. Alsbrook, Plant City, or Doctor J. Harris Pier-

pont, Pensacola. Doctor James H. Pittman of Jacksonville is chairman of the Committee on Scientific Work of the Florida Railway Surgeons' Association. Doctor E. W. Warren, Palatka, secretary. Communications relative to the Railway Surgeons' Association should be addressed to one of these gentlemen.

Special railroad facilities for those attending the Pensacola meeting are being arranged for. Private cars in a sufficient number to take care of all members will be attached to the regular Seaboard Railway train leaving Jacksonville at 5.15 p. m. It is suggested that all members desirous of having space in one of these private cars address Mr. G. Z. Phillips, Assistant Passenger Traffic Manager, 409 Hill Building, Jacksonville. Checks may accompany requests for reservations, the Pullman rates being as follows: Drawing room, \$16.20; upper berth, \$4.46; lower berth, \$3.56; the railroad fare is \$14.35. The foregoing figures include war tax and surtax. Let the old fellows crawl into the lower berths; all young men should help the cause by being satisfied with an upper berth. Reservations should be on file not later than May 6th. Special dining car accommodations will also be provided; in fact, a regular smoker banquet on the way over has been suggested and will be pulled if the crowd come along.

Pensacola physicians are sparing no pains to make the meeting one of the most attractive and interesting ever held since the organization was formed.

G. E. H.

CLEARNESS IN MEDICAL SPEECH.

The above caption was the title of the Chairman's address* presented before the Section on Medicine at the seventy-first annual session of the American Medical Association. Dr. McLester in a most interesting manner describes the many faults of

*McLester, James S.: *Clearness in Medical Speech*, *Journal of the American Medical Association*, May 8, 1920, Vol. 74, pp. 1295-1296.

medical men in presenting subjects before the section. His constructive criticism as applied to papers read before his section, in which he has held office for five years, may certainly be handed down to medical men appearing before their state associations and also to the essayists holding forth before their county society. How frequently we hear papers presenting a most pertinent message so crude in construction or so badly read as to absolutely kill their usefulness.

Dr. McLester's views on the "Essentials of a Good Paper" are well worth summarizing. He states: "The author should have something worth saying; he must tell of carefully planned original investigation, must be able to establish definitely new facts or principles, or must give such a complete summary in some particular field as will justify deductions of value; his material should be presented in a clear, agreeable form, requiring of his hearers the least degree of effort. The writer should be brief; he should be able to awaken interest in his subject.

"A summary embodying the author's conclusion is always of advantage, the title should be accurate, expressive and brief.

"Poor pronunciation and rapidity of speech are deadly faults.

"Complicated charts that convey a great mass of unreliable facts are difficult to read and should be avoided."

It is not with the idea of discouraging prospective essayists at the coming meeting of our State Association that attention is called to Dr. McLester's address at this time, but rather with the hope that it will instil into our members the determination to prepare better papers. Nor do we intend to infer that the members of the Florida Medical Association are especially recalcitrant in the matter under discussion, but it is believed that Dr. McLester's criticisms directed at members of the Section on Medicine of the American Medical Association can be taken with grace by our readers and future contributors.

G. E. H.

PROPAGANDA FOR REFORM.

GLOVER'S CANCER SERUM.—In an envelope bearing the name "T. J. Glover, Research Laboratory, Toronto, Canada," but mailed, apparently, from New York, physicians are receiving "literature" about Dr. Glover's Cancer Serum. This is stated to be a serum from immunized horses "between the ages of seven and nine years, of the roan type," and is claimed to have a specific action on every known type of cancer. The advertising offers to send the serum on receipt of price. While this would indicate that the Glover Research Laboratory had received a permit from the U. S. Public Health Service licensing the interstate sale of the serum in the United States, no such license has been issued. (*Jour. A. M. A.*, January 1, 1921, p. 52.)

DIPHThERIA ANTITOXIN AND DIPHThERIA BACILLI. — The well-established curative properties of diphtheria antitoxin must not be confused with its possible value as a prophylactic against the disease. Attempts have been made to apply diphtheria antitoxin locally in the pharynx and nares with the hope of eradicating the objectionable microorganisms that may have found lodgment there. Recent investigations to determine the effect of diphtheria antitoxin in preventing lodgment in and growth of the diphtheria bacilli in the nasal passages of animals were entirely negative. (*Jour. A. M. A.*, January 1, 1921, p. 41.)

PHARMACEUTICAL BARNUMS.—The exploiter of nostrums to the medical profession, realizing that at least a pretense must be made of giving the composition of medicaments offered to the physician, declares that his clay poultice has for its base "anhydrous and levigated argillaceous mineral." This sounds much more imposing than "dry and finely powdered clay," and satisfies by its very sonorousness. Now comes a product exploited chiefly to members of the dental profession, but also, it seems, to physicians. These are "activated" tablets which are "anodyne, analgesic, febrifuge sedative, exercising (sic) antineuralgic and antirheumatic

action." Their composition is stated to be "An activated, balanced combination of the mono-acetyl-derivative of para-amidophenetol together with a feebly basic substance in the alkaloidal state from the *Thea-Sinensis*." This means nothing more than acetphenetidin (phenacetine) and caffeine. (*Jour. A. M. A.*, January 1, 1921, p. 42.)

ECHINACEA.—Intelligent members of the medical profession must be well aware that both the Pharmacopeia of the United States and the National Formulary include many products that can scarcely be justified as medicinal on the basis of scientific consideration. Among the products included in the National Formulary is the fluidextract of echinacea. In 1909 a report of the Council on Pharmacy and Chemistry denied echinacea a place in New and Nonofficial Remedies because there was no evidence to show that it possessed therapeutic value. Despite this, echinacea is used extensively. The fluidextract and the tincture are made in enormous quantities, and the root enters into the composition of a large number of "patent," proprietary and non-secret mixtures. For this reason Couch and Giltner of the U. S. Bureau of Animal Industry made an extensive experimental study of echinacea therapy. Animal experiments designed to determine whether the drug possessed the properties that are ascribed to it gave negative results in every instance. (*Jour. A. M. A.*, January 1, 1921, p. 39.)

MORE MISBRANDED NOSTRUMS.—The following products have been the subject of prosecution by the federal authorities charged with the enforcement of the Food and Drugs Act: Dermacilia Eye Remedy and Ointment (The Dermacilia Manufacturing Co.), the first falsely claimed to be an effective treatment and cure for sore eyes of all forms, the second falsely claimed to be effective for all skin and scalp affection and for all kinds of eczema. Roger's Liverwort, Tar and Canchalagua (Williams Manufacturing Co.), falsely and fraudulently recommended for treatment of consumption, asthma, whooping cough, influenza, etc. Valesco (Alhosan

Chemical Co.), falsely and fraudulently recommended as a remedy for tuberculosis, asthma, pneumonia, etc. (*Jour. A. M. A.*, January 1, 1921, p. 52.)

SERUMS AND VACCINES IN THERAPY.—In the development of serums and vaccines, scientific investigation and experimentation have preceded clinical tests of those products which have proved of permanent worth. Whenever the clinical use of serums and vaccines had proceeded beyond well established facts determined by laboratory research, the result has usually been disappointing. To submit a serum or vaccine for clinical trial without successful preliminary laboratory investigation of its probable worth is an imposition on the profession. The success of diphtheria antitoxin and anti-typhoid vaccine has prejudiced the profession and public in favor of vaccines and serums so that they are willing to accept a new serum or vaccine simply because it is a serum or vaccine. In his introduction to a series of articles on serum and vaccine therapy which is now being published by the Council on Pharmacy and Chemistry, Flexner points out in only a few instances has the anticipation been realized that a curative antiserum for each disease would be discovered. The history of antipneumococcus serum affords a striking example of the difficulties and pitfalls that are encountered in the development of remedies of this class. Thus far only one therapeutically active serum, Type I, has been developed, and this serum is not effective against infections by other types of pneumococci. Despite this, we are being offered today for clinical use "polyvalent" antipneumococcic serums recommended by the makers for the use in all types of pneumococcus infection. (*Jour. A. M. A.*, January 8, 1921, p. 115.)

INHALATION THERAPY.—The possibility of effecting absorption of many drugs, other than the anesthetics, by inhalation is beyond question. Mercury, for example, has been so administered. The difficulties that attend such a procedure relate in particular to the uncertainties of accurate dosage. It has lately been

demonstrated that calcium chloride solutions can be nebulized for inhalation so that the salt is absorbed from the respiratory tract. Since absorption of calcium from the alimentary tract is slow, indefinite and undependable, while subcutaneous or intravenous administration is objectionable or impracticable or both, attention becomes directed to the inhalation method of administering calcium. However, while small quantities of calcium are of dubious value, recent investigations indicate that the administration of larger amounts by inhalation methods is liable to exceed the limits of advisable concentration in the blood without any suitable mode of regulation. These findings may be a timely warning at a period when therapeutic novelties are likely to be proposed in increasing numbers. (*Jour. A. M. A.*, January 8, 1921, p. 116.)

MORE MISBRANDED VENEREAL NOSTRUMS.

—The following products have been the subject of prosecution by the federal authorities on the ground that the curative claims made for them were false and fraudulent: Saxon Gonorrhea Injection (Saxon Co.), represented as a treatment, remedy and cure for gonorrhea, gleet and the prevention of stricture. Santalets (Sharp & Dohme), represented as a treatment, remedy and cure for gonorrhea, gleet, catarrh of the bladder—acute or chronic—whether due to gonorrheal infection or other causes. Specific Globules No. 31-77 (Sharp & Dohme), claimed to be an improved combination for the treatment of gonorrhea and its complications. Methylets (Sharp & Dohme), claimed to be of great value in all forms of urethritis, especially gonorrheal and allied varieties. Saxon Methygon Tablets (Saxon Co.), claimed to be a reliable remedy for treating gonorrhea and gleet. Columbia Short Stop (Columbus Drug Co.), recommended for "gonorrhea, gleet, running range, inflammation of the kidneys and bladder." Allan's Compound Extract of Sarsaparilla with Iodide (Allan-Pfeiffer Chemical Co.), claimed to be the best known remedy for syphilis, a powerful purifier of the blood and

to have other curative effects. Bonkocine (J. E. Gasson), sold with the claim that "well defined cases of gonorrhea yield to treatment in one to five days, chronic gonorrhea and gleet in five to ten days, provided they are not complicated with stricture or enlarged prostate gland." (*Jour. A. M. A.*, January 8, 1921, p. 126.)

TONA-VIN. — To those familiar with nostrum advertising, the advertisements which have appeared in newspapers for "Tona-Vin" made it fairly easy to classify the product as probably belonging to the class of alcoholic nostrums that are being born over night in order to meet—or beat—the exigencies of the prohibition law. According to the label the preparation contains "soluble iron and quinin, fluid extract of senna leaves, wild cherry and aromatics." The A. M. A. Chemical Laboratory analyzed Tona-Vin and reported that it is a dark-brownish liquid, having an odor like wild cherry and wine and a slightly bitter, somewhat sour taste. The presence of 18 per cent of alcohol is declared on the label. The analysis demonstrated that the amount of quinin was so small that, to obtain a single tonic dose of quinin, it would be necessary to drink the contents of about 1.4 bottles of the preparation. The chemists further found that, to obtain an average dose of iron, the individual would be obliged to drink the contents of an entire bottle of Tona-Vin. When one ounce was dealcoholized and swallowed by a healthy man, no effect except a doubtfully laxative action was noted. Evidently Tona-Vin is not sufficiently medicated to prevent its use in moderate amounts as beverage. There is, of course, no legitimate reason for administering such drugs as iron and quinin and senna, in ridiculously small doses, in a menstruum containing 18 per cent of alcohol. (*Jour. A. M. A.*, January 15, 1921, p. 193.)

POLYVALENT VACCINES FOR COLDS. — At least five commercial manufacturers of biologic products make and push the sale of vaccines to prevent colds. Of these at least two, from time to time, have added new

strains of bacteria to the formulæ with which they originally introduced their products, so that seventy-five or eighty different types of bacteria are now included. Every year different types, varieties and species of bacteria have been associated with colds in different parts of the country. Presuming—although it has never been proved—that any vaccine has value in preventing colds, the logical thing to do is to prepare a specific vaccine for each form of cold in each part of the country. Commercially it is much more profitable to mix all the bacteria together, to prepare a vaccine and to inject this into the patient in the hope that some organism will produce antigens which will find their mates. The present-day shotgun biologic mixture is more ridiculous than the old shotgun proprietary—and a greater menace to public health and to scientific medicine. (*Jour. A. M. A.*, January 15, 1921, p. 182.)

SPIROCIDES NOT ADMITTED TO N. N. R.—The Council on Pharmacy and Chemistry reports that Spirocid is advertised as a new and successful treatment of syphilis by fumigation and inhalation. The product is furnished in the form of tablets which are stated to be composed of metallic mercury, copper sulphate, cypress cones, henna, nutgall and dried pomegranate. Experiments in the A. M. A. Chemical Laboratory showed that when the tablets are ignited the organic constituents are consumed, the mercury is volatilized and most, if not all, of the copper remains behind. For use, the patient sits on a chair, the tablet is ignited, and the patient is covered with a sheet so that he will inhale the mercury vapors produced. The Council obtained the opinion of syphilographers with regard to the evidence submitted by the Spirocid Corporation, which markets the product, and as to the advisability of giving recognition to a method for the administration of mercury by inhalation. In consideration of the opinions expressed by its consultants, the Council declared Spirocid inadmissible to New and Nonofficial Remedies because, first, the claims made for it are unproved and unwarranted; secondly, the

routine use of an inexact method for the administration of mercury is detrimental to sound therapy; and thirdly, the name is not descriptive of the composition, thus failing to remind the physician who uses the pastils that he is administering metallic mercury. (*Jour. A. M. A.*, January 22, 1921, p. 259.)

HELMITOL OMITTED FROM N. N. R.—Helmitol is hexamethylenamin methylencitrate. It was introduced with the claim that it was superior to hexamethylenamin (which acts in acid fluids only) in that it is equally efficient whether the urine is alkaline or acid. In 1918 the Bayer Co., which then marketed the product in the United States, was notified that the Council on Pharmacy and Chemistry questioned the claims and desired evidence for their substantiation. In 1919 the same notification was sent the Winthrop Chemical Co., which in the mean time had secured control of the product. Pending the submission of evidence, the Council continued Helmitol in New and Nonofficial Remedies with the statement that the action and uses were those of hexamethylenamin. Now the Council on Pharmacy and Chemistry announces that Helmitol has been omitted from New and Nonofficial Remedies for the reason that the claims under which it was introduced have been disproved by P. J. Hanzlik, who demonstrated that the alkalinity required to split off formaldehyd from helmitol is greater than exists in urine, even in the advanced ammoniacal fermentation. (*Jour. A. M. A.*, January 22, 1921, p. 260.)

MORE MISBRANDED NOSTRUMS.—The following preparations have been the subject of prosecution by the federal authorities charged with the enforcement of the Food and Drug Act: Benetol Suppositories (Benetol Co.), misbranded in that unwarranted therapeutic claims were made for them. Vinol (F. Stearns & Co.), misbranded in that false and fraudulent claims for curative effects were made for it. Mir-A-Co (Mir-A-Co Co.), sold with false and misleading statements regarding its composition and with fraudulent therapeutic claims. Novita Globules; Novita Capsules; Novita Salve, Stainless;

Novita Salve, Brown (Novita Co.), misbranded in that the therapeutic claims were false and fraudulent. Pepsobaxatone (Burlingame Chemical Co.), adulterated in that it did not contain diastase or pancreatin as claimed and that the therapeutic claims made for it were false and fraudulent. Alkano (Alkano Remedy Co.), offered under false and fraudulent therapeutic claims. (*Jour. A. M. A.*, January 29, 1921, p. 326.)

BIOLOGIC THERAPY. — The various problems, the contradictory opinions and the commercialization of biologic therapy, induced the Council on Pharmacy and Chemistry to appoint a committee to prepare and publish an authoritative review of this subject. The object of the series, which has now been published, was to present to physicians concise, authoritative statements concerning indications, contraindications, methods of administration, dosage, value and possible danger of serums, vaccines and non-specific proteins in the treatment of infectious diseases. (*Jour. A. M. A.*, January 29, 1921, p. 318.)

QUININ AND UREA HYDROCHLORID FOR LOCAL ANESTHESIA. — Quinin is a protoplasmic poison, and tissue necrosis may be caused by strong solutions of quinin salts. That this deleterious reaction actually does occur and has mitigated against the general use of quinin and urea hydrochlorid is confirmed by the report of the Committee of the A. M. A. on the Advantages and Disadvantages of Local Anesthesia in Nose and Throat Work. The committee reported that the only local anesthetic that produces edema and sloughing is quinin and urea hydrochlorid. The committee found that, as this local anesthetic has been abandoned in other fields of medicine, so it has been discarded for use in nose and throat operations. Two physicians who had published articles extolling the value of quinin and urea hydrochlorid in nose and throat operations now state that they have discontinued its use, though they had not published this unfavorable conclusion. (*Jour. A. M. A.*, August 21, 1920, p. 559.)

FOREIGN PROTEIN THERAPY. — While striking clinical changes, sometimes to the apparent profit of the patient—but sometimes decidedly otherwise—may follow the injection of foreign protein, it is generally agreed that the method lacks the requisite amount of carefully controlled observations which would entitle it to acceptance as an approved procedure for general use. Most serious is the attempt of pharmaceutical houses to push the use of alleged specific methods of treatment, which the thinking physician will at once realize are methods of inducing protein shock. Research with such products in laboratories and in hospitals under suitable control may be permissible, but indiscriminate use in general practice is a far different matter. (*Jour. A. M. A.*, January 29, 1921, p. 315.)

LYKO. — This is an alcoholic tonic which has been widely advertised in the newspapers. It is put out by the Lyko Medicine Co., Kansas City, Mo. Lyko is claimed to stimulate the appetite, tone up the digestive organs and to have laxative qualities. It is said to contain caffein, kola, phenolphthalein and cascara sagrada. The advertising does not discuss the most powerful ingredient, alcohol, although the label declares the presence of 23 per cent of this drug. As a result of an exhaustive examination, the A. M. A. Laboratory concludes that Lyko is essentially a sweetened solution containing about 22.2 per cent of alcohol together with insignificant amounts of caffein, cascara extractives and phenolphthalein. There was no evidence to show that the product is sufficiently medicated to prevent it being used as a beverage. (*Jour. A. M. A.*, September 11, 1920, p. 757.)

NATURE'S CREATION. — This is one of the fake consumption cures. It was originally put on the market as an absolute cure for syphilis. When analyzed in the A. M. A. Laboratory it was found to be essentially a solution of potassium iodid in a weakly alcoholic medium containing vegetable extractives and flavoring matter, and small quantities of inorganic salts. (*Jour. A. M. A.*, September 11, 1920, p. 758.)

MURRAY W. SEAGEARS, M. D.
1872—1921.

In the death of Murray W. Seagears the Florida Medical profession have sustained a loss that is hard to fully realize. A man of wonderful physique, an indefatigable worker with rather more than the average opportunity, his being cut off in the prime of life was a shock to the whole state. A man of wonderful personality, always greeting friends with a kindly word and pleasing smile, he acquired innumerable and an ever-increasing number of friends. There are few men as much loved as he was, it is doubtful if there are any more so. As Chief Surgeon of the Florida East Coast Railway his personality resulted in an *esprit de corps* in the Medical Department of this corporation that could not be excelled. Living in a community where the wealth of the United States congregate during the winter months, did not at any time prevent him from giving kindly advice and his professional services to the poor in their distress. He was never unmindful of the sorrows and anxieties of others and whenever possible was ready with a helping hand. He made a brave fight through an illness covering a period of four weeks, the end coming during the early morning of April 19th. The following excerpt from an editorial in the lay press of his home city emphasizes the love in which he was held in his own community:

"Following the death this morning of Dr. Murray W. Seagears, a hush of reverence, respect and deep grief fell upon

bowed heads throughout the community and many were the eyes that were moist. Business men, women, children, people in all walks and stations of life were saddened and expressed the great personal loss they had sustained. Few illnesses in the history of St. Augustine have caused universal depression as that of

Doctor Seagears, and as he lingered for days between life and death all classes and conditions of people prayed that he might be spared."

Dr. Murray W. Seagears was born in Bloomingburg, N. Y., and received his classical education at the Delhi Literary Institute of Franklin, N. Y. He graduated in medicine from the New York University Medical College in 1895, receiving the appointment of House Surgeon to the New York University Post-graduate Hospi-



tal, after which service he came to Florida and has since practiced his profession continuously in St. Augustine. For the past many years he was House Physician of the Flagler hotels in St. Augustine, receiving the appointment as Chief Surgeon of the Florida East Coast Railway in 1914. He was a member of the Phi Gamma Delta Greek Letter College Fraternity, the Benevolent and Protective Order of Elks, the Masons and the St. Augustine Rotary Club.

At the time of his death he was President of the Florida Railway Surgeons' Association and Chairman of the Committee on Scientific Work of the Florida Medical Association.

G. E. H.

GOVERNOR HARDEE ON MEDICAL LEGISLATION.

(Excerpt from Governor's Message.)

"I am sure there is no one subject of more direct public concern than the health, physical and mental, of our people. Our progress in the future will depend very largely upon the virility of the citizenship of the state. Health must play a very important part. Its work must be educational, citizen is of strong body and sound mind. In this respect the State Board of Health must play a very important part. Its work must be educational, teaching the people not only the importance of good health, but likewise instructing them how it is best to be secured and maintained. We have a Board of Health, composed of three members, who employ a State Health Officer, who is charged with the administration of those policies, means and measures which may be prescribed by the board. I feel that its work in the past has been highly conducive to the best interest of the people, and that the department should be adequately maintained and the State Health Officer paid an adequate salary. There should be an act passed at the present session of the legislature defining most specially the authority of the State Health Officer, and such an act should provide for his appointment by the Governor. At present he is neither an official elected by the people, nor one appointed by the Governor. We should provide for the examination of the children of the public schools, providing sufficient funds for such examination, or for the cooperation of counties and cities in such examination for the expense thereof. A bureau of vital statistics should be very carefully maintained, and all physicians should, under penalty of law, be required to make prompt and full report to such bureau. We should also require, by statute, that all diseases declared notifiable by the State Board of Health should be promptly reported thereto. We should also have most adequate supervision by the State Board of Health for quack institutions, as well as the advertisement and sale of quack nostrums and remedies, the use of which undermines the health and energies of the people rather than afford a cure.

"We should have a more effective system of examination and licensing of medical practitioners. This not only for the protection of the high and honorable members of a great profession who, through the outlay of much time and expense, have prepared themselves for practice, and who should be protected against the unscrupulous and unprepared man, but the protection of the public against the unprepared and uninformed practitioner, is of primary importance. It is for the protection of the people primarily which causes me to invite your attention to the necessity for a more effective system, looking to the issuance of licenses to practice."

PRELIMINARY PROGRAM
OF THE SECOND ANNUAL MEETING OF THE
FLORIDA RAILWAY SURGEONS'
ASSOCIATION

To be held at Pensacola, May 9, 1921.

OFFICERS OF THE ASSOCIATION.

W. P. Adamson, M. D. *President*
E. W. Warren, M. D. *Secretary*
James H. Pittman, M. D.,
Chairman, Committee on Scientific Work

MAY 9TH, 2 P. M.

The Indirect Influence of the Railroad Surgeon,
Robert B. Slocum, M.D., *Superintendent and Medical Director Atlantic Coast Line Railroad Company.*

Accident Hernia From the Standpoint of Liability,
L. S. Oppenheimer, M. D.

Hernia, Frederick J. Waas, M. D.

The Report of Some Interesting Fractures: With a
Discussion of Their Management, J. S. Turber-
ville, M. D.

The Importance of Conserving Vital Power in Ren-
dering First Aid, Mary Freeman, M. D.

Subconjunctiva Injections in Eye Injuries, W. Herbert
Adams, M. D.

The Hodgen Splint, Robert B. Harkness, M. D.
Election of Officers.

PRELIMINARY PROGRAM
OF THE FORTY-EIGHTH ANNUAL MEETING
OF THE FLORIDA MEDICAL ASSOCIATION
*To be held at Pensacola, May 10 and 11,
1921.*

TUESDAY, MAY 10TH, 10.30 A. M.

Call to order by Dr. S. Mallory Kennedy, *Chairman,
Committee on Arrangements.*

Opening Prayer—Rev. A. J. Moncrief, D. D.

Address of Welcome, in behalf of the city of Pensa-
cola—Hon. M. G. Hoffman, introduced by Dr. S.
Mallory Kennedy, *Chairman, Committee on Ar-
rangements.*

Address of Welcome, in behalf of the Escambia
County Medical Society—Clarence Hutchinson,
M. D.

Response to Addresses of Welcome—J. R. McEach-
ern, M. D.

President's Address, Dr. W. P. Adamson, Tampa.

Report of the Executive Committee.

Report of the Secretary.

Report of the Treasurer.

Report of the Editor.

Organization of the House of Delegates.

2 P. M.—SCIENTIFIC ASSEMBLY, PEDIATRIC SECTION.

James D. Love, M. D., *Chairman.*

M. B. Herlong, M. D., *Secretary.*

Simplified Infant Feeding, F. Clifton Moor, M. D.

Vaccine Therapy in Pertussis, Wm. E. Ross, M. D.

Diphtheria, B. L. Arms, M. D.

Hydrocephalus, M. B. Herlong, M. D.

Indigestion of the Young Infant, James H. Fellows,
M. D.

The Teaching of Personal Hygiene to Children,
Grace Whitford, M. D.

Election of sectional officers will follow the Scien-
tific Program.

4.30 P. M.—SCIENTIFIC ASSEMBLY.

J. Harris Pierpont, M. D., *Chairman.*
Florida's Program for the Eradication and Control
of Venereal Diseases, George A. Dame, M. D.
Plague Eradication, S. S. Spencer, M. D.

8 P. M.

An informal smoker-banquet will be given the mem-
bers and visiting guests by the Escambia County
Medical Society, at the San Carlos Hotel.

Past-President Ralph N. Greene, M. D., *Toastmaster.*
At the same hour the visiting ladies will be tendered
a theatre party at the Isis Theatre.

MAY 11TH, 8 A. M.

The members of the Association with their guests
and visiting ladies will be tendered a boat ride on
Pensacola Bay, and given an opportunity to witness
flights of seaplanes and dirigibles at the Naval
Air Station.

9 A. M.—SCIENTIFIC ASSEMBLY.

J. Harris Pierpont, M. D., *Chairman.*
Treatment of Cutaneous Growths: With a Consid-
eration of Radium and X-Ray Therapy, J. L.
Kirby-Smith, M. D.

The Physiological Basis for Radium Therapy, Gerry
R. Holden, M. D.

The Early Diagnosis of Carcinoma of the Cervix,
Wm. M. Rowlett, M. D.

Report on a Series of Fifty Operations on the Thy-
roid Gland, John S. Helms, M. D.

Pyuria, J. C. Vinson, M. D.

Ureteral Stricture: With Report of Cases, E. H.
Teeter, M. D.

Two Anomalous Pregnancies, J. C. Davis, M. D.

12 NOON.

Election of Officers.

1 P. M.

Meeting of the House of Delegates, the President in
the chair.

2 P. M.—SCIENTIFIC ASSEMBLY.

J. Harris Pierpont M. D., *Chairman.*
Gastroptosis, Seale Harris, M. D., Birmingham, Ala.
Some Remarks on the Administration of Silver Sal-
varsan, Ralph N. Greene, M. D.

Differential Diagnosis of Perforated Gastric Ulcer,
Angina Pectoris and Gall-Stones, Julian Gammon,
M. D.

The Hodgen Splint, R. B. Harkness, M. D.

Tic-Douloureux, James H. Randolph, M. D.

The Professional, Ethical and Business Relation of
Physician and Surgeon, R. R. Kime, M. D.

Trachoma and Follicular Conjunctivitis, A. K. Wil-
son, M. D.

All meetings of the Scientific Assembly and those
of the House of Delegates will be held in the Audi-
torium of the San Carlos Hotel.

Hotel Headquarters, San Carlos Hotel.

ENTERTAINMENTS.

MAY 10TH, 3.30 P. M.

A ride through the city, Naval Air Station, Fort
Barancas, followed by a tea at the Country Club,
will be tendered the visiting ladies.

8 P. M.

Smoker Banquet at the San Carlos Hotel.

Theatre Party at the Isis Theatre for visiting
ladies.

MAY 11TH, 8 A. M.

Boat rides on Pensacola Bay for all members,
guests and visiting ladies.

CASE RECORDS.*

(ANTE-MORTEM AND POST-MORTEM) AS USED IN WEEKLY
CLINICO-PATHOLOGICAL EXERCISES AT THE
MASSACHUSETTS GENERAL HOSPITAL
EDITED FOR THE USE OF PRACTITIONERS BY

RICHARD C. CABOT, M. D., AND
HUGH CABOT, M. D.

F. M. PAINTER, ASSISTANT EDITOR

CASE 6112.

A Canadian housewife of thirty-one entered November 6th for relief of vomiting.

F. H. Good.

P. H. She had never had good health, but had always suffered from aches and pains. In childhood she had measles and whooping cough. She and her husband had been treated for syphilis at the South Medical Department. Between July 10th and August 14th she had six injections of 606, and between August 21st and October 9th seven treatments of gray oil. Her first four children were living and well. She had lost five by possible syphilis, and had had one stillborn and a miscarriage. For years she had had occipital headache. She had always had pain in both eyes and difficulty in reading or sewing. She occasionally urinated at night. She had leucorrhea at intervals. Six months ago she weighed 228, her best weight. Her present weight was 207.

Habits. Good.

P. I. For nine weeks she had been vomiting, at first only in the morning, but later all food half an hour after meals and also a frothy phlegm-like material at all times of the day or night. Her headaches had now become generalized and constant, but generally worse soon after vomiting, when she also felt dizzy. Since the onset she had had blurred vision and at times even diplopia. She had soreness all over the abdomen, more severe at the pit of the stomach, constant, without relation to meals or posture, more severe for half an hour after vomiting. For three weeks she had had pain in the back only with exercise. For two weeks her skin

had been yellow, and she thought was becoming more intensely so. She had grown gradually weaker, and so dyspneic that she could no longer walk about the house. For two weeks she had had continuous flowing of a light brownish material. Very recently she had had marked tremor of the hands, difficulty in feeding herself, and dizziness with nausea on sitting up. For four days she had urinated only once in twenty-four hours. She had no edema. Her appetite was poor.

P. E. She was well-nourished, markedly jaundiced. Weight November 13th, 176 pounds. The tongue was protruded in mid-line with slight tremor. The *lungs* were negative. The *heart* showed no enlargement. The action was slightly rapid. The *pulses* and *arteries* were normal. Systolic *B. P.* 170-160, diastolic 90-85. The *abdomen*, *genitals*, *pelvic examination*, *extremities*, *pupils* and *reflexes* were negative.

Until the day of death *T.* 96.5°-98.6°. *P.* at entrance 150, then 76-96 until November 15th. *R.* 20-29. *Urine:* 5 10-25, sp. gr. 1020-1036, red at four of five examinations, cloudy at three, alkaline at one, a trace to a large trace of albumin at two, bile at another, loaded with leucocytes at all, red corpuscles at three (menstruating at the first). No leucin or tyrosin crystals at three examinations. *Renal function* 40% (?). *Blood:* Hgb. 85% (?). Leucocytes 8,600-15,900. Polynuclears 89%. Reds 4,928,000; achromia. *Coagulation time* 4½-8 minutes. *Bleeding time* 2½ minutes. *Nouprotein nitrogen* 47.5 mgm. *Wassermann* strongly positive (bile). *X-ray:* No evidence of stone in any part of the genito-urinary tract or gall-bladder. The stomach contained a small residue at six hours, and its peristalsis was somewhat hyperactive. The suggestion was irritation with some spasm of the pylorus, perhaps due to pathology outside the stomach. *South Medical consultation:* "The only jaundice that I have seen following arsphenamin, when I believed it to be the cause, came on two or three days after injection and was associated with a marked erythema and in certain cases

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a varied degree of dermatitis. A lumbar puncture may help us with the cause of blurred vision as well as an eye consultation." *Lumbar puncture* November 13th negative; Wassermann on the fluid negative.

After the lumbar puncture the pulse was usually 80-125. Although the patient's obesity made it difficult to determine the liver dullness it was thought November 17th to be distinctly decreased. The patient seemed rather drowsy that noon, in the afternoon slept heavily, and at five o'clock was in coma, with normal pulse, respiration, color, and reflexes. The pupils were slightly dilated, the corneal reflexes absent. The fundi were normal. Physical examination showed nothing. In the evening she spoke incoherently and would not answer questions. She remained in this condition, showing negativism. November 20th another lumbar puncture gave 7 c.c. of fluid, the first c.c. under increased pressure and contaminated with blood, the second and third tubes under normal pressure and clear; two cells; ammonium sulphate definitely positive, alcohol more or less positive, Wassermann negative. Next day the chief of service found a questionable ankle clonus on the left, absent Babinski on the left, slight on the right, knee-jerks normal, extent of liver dullness much decreased, some hemorrhagic spots on the trunk, jaundice of sclerae increased. The patient was much deeper in coma, could not even be roused to groan, and was incontinent. She rapidly went downhill. November 22d the temperature rose to 100.1°, the respiration to 40, and she died.

CASE 6112.

DISCUSSION

BY DR. RICHARD C. CABOT.

NOTES ON THE RECORD.

In her treatment she had had a lot of mercury and arsenic, and one hypothesis we shall have to consider later is whether that is not what she died of.

The evidence of syphilis with the treatment of syphilis is the only thing we have as a background for the present illness.

I think we can naturally suppose that that abdominal soreness was due to the vomiting itself. Anybody who vomits hard has soreness in the epigastrium.

The two things that history makes us think of are some local brain disease—tumor or syphilitic endarteritis—and poisoning by treatment. That will come out more clearly as we go on to the physical examination.

She was losing weight pretty fast.

We cannot measure hemoglobin well in a jaundiced blood.

The positive Wassermann does not mean anything because there was bile. In the presence of bile we cannot tell anything about the Wassermann.

There was a negative X-ray examination of all three tracts, biliary, urinary, and gastro-intestinal, so far as they could make out.

DIFFERENTIAL DIAGNOSIS.

The two hypotheses mentioned before still seem to me the only ones to consider—local brain disease or acute hepatitis.

She has had syphilis, which always makes us expect local disease of the central nervous system sooner or later. But I cannot identify any such disease there. She has had headaches, she has had dizziness, she has had blurred and once double vision, and finally coma. But at no time has she had anything whereby we can say "trouble *here* in the brain rather than *there*." The fundi were normal, which is against tumor. There was never any paralysis, which is against endarteritis or hemorrhage. I feel that if there was anything wrong in the central nervous system it had nothing to do with her fatal illness.

Now what local diseases can cause jaundice? (1) She is fat and of the sex which gall-stones favor, but she has had no pain. There is no evidence that the gall-bladder is enlarged. Gall-stones do not kill like this. They kill from cholemia in the course of months, but not in a few weeks. (2) Cancer, perhaps of the pancreas or the biliary tract

itself. Again the death is too sudden here. She has not lost flesh, and I do not see that any obstructive form of cancer will account for the rapid course to death.

Toxemic jaundice is left us, and we have no evidence of any infectious type such as is due to sepsis or malaria. Hence I think it is acute toxic hepatitis or "acute yellow atrophy," of which we have seen so much more than ever before during this last autumn, and which I cannot help thinking is due to the present make of the arsenic preparations, or to the larger number of people receiving them, for certainly the amount of hepatitis we have seen lately is astounding. There is a suggestion of mercury poisoning. Tremor is not a symptom of arsenical poisoning. It is of mercury. If she was hypersensitive to one drug, arsenic, she may have been sensitive to the other, mercury. So it seems to me the evidence is that death was due to poisoning from arsenic and mercury, their effects on the liver in the form of acute hepatitis.

That she had syphilis I do not doubt. That we shall find any anatomical evidence of that syphilis is very doubtful. The head was not examined, so we shall not consider anything there. I do not believe there were any lesions there. The ankle clonus and Babinski do not seem significant enough to make us suppose any brain lesion.

It is very characteristic of this disease, acute hepatitis, that the person goes into coma with no focal brain symptoms or changes in the eye grounds. When a jaundiced person goes into coma one thinks of hepatitis. We see something of the same phenomenon in the last stages of cirrhosis, only there there has generally been more evidence of portal obstruction.

CLINICAL DIAGNOSIS

(FROM HOSPITAL RECORD)

Syphilis.

DR. RICHARD C. CABOT'S
DIAGNOSIS.

Acute yellow atrophy of the liver.

ANATOMICAL DIAGNOSIS.

1. Primary fatal lesion:
Acute yellow atrophy of the liver.
2. Secondary or terminal lesions:
Icterus.
Ascites.
Soft spleen.
Acute degeneration of pancreas, adrenals, and kidneys.
Marked hemorrhagic edema of the lungs.
Small hemorrhagic areas endocardium epicardium.
Small hemorrhagic areas of the endocardium and epicardium.
3. Historical landmarks:
Slight chronic pleuritis, right.

DR. RICHARDSON: No evidence of syphilis was found in any of the organs.

DR. CABOT: Can you account for the ascites and hemorrhagic edema of the lungs?

DR. RICHARDSON: The edema of the lungs I should associate with the toxic condition, but I cannot account for the ascites except that ascites occurs in some cases of cirrhosis of the liver showing marked changes in the liver tissue.

DR. CABOT: It was not a circulatory affair? The heart did not show evidence of any damage that would make it so weak?

DR. RICHARDSON: Nothing except some dilatation and flabby myocardium. It weighed 290 grams. That is a little large, but we must remember that she was a very stout woman. I do not understand the ascites unless it came with the change in the liver.

DR. CABOT: Do you remember having seen it with others of these cases?

DR. RICHARDSON: Some cases have it and others do not.

DR. CABOT: I am not wrong in saying that we have had an extraordinary run of these cases? Have you any idea why?

DR. RICHARDSON: No, unless the hypothesis that they are associated with salvarsan is correct. I have no reason to associate it with influenza. I have never seen any livers in influenza which resembled this.

The acute degeneration of the kidneys and

pancreas here was rather well marked. It recalls the question asked by Dr. Cabot the other day as to whether the kidney tissue cells were affected by the poison in the same way as the cells of the liver tissue. Evidently here they were hit, because the kidney tissue was yellowish and pretty soft.

The name I should give to the condition is toxic degeneration of the liver. The whole picture is one of toxic atrophy. As to whether the cases before the days of salvarsan were due to another toxin or a similar substance it is impossible to say yet. But these later cases seem to be in association with the administration of salvarsan. In this particular case we found no evidence of syphilis.

CASE 6461.

An American housewife of thirty-four entered June 8, 1920.

F. H. Her mother died of arteriosclerosis, one grandmother of tuberculosis.

P. H. She had always been nervous and rather thin. As a child she had measles, chickenpox, whooping cough and diphtheria. Since childhood she had urinated once at night. She always had sick headache at the beginning of the monthly periods. She had always had stomach trouble. Acids soured on her stomach, and she had much gas. For many years she had had slight leukorrhea. At twenty-one she had her tonsils and adenoids removed. At the birth of the first of her two children she had hemorrhage, chill and fever. Before the birth of the second child she had albuminuria, and was on a milk diet for three months. After labor this cleared up. Since the birth of her children her bowels had always been constipated. Following periods of constipation she had attacks of diarrhea. Six and a half years ago she had bronchitis lasting several months. Since then she had had four or five more attacks. During the past winter she had had two or three sore throats. For the past three months she had had headache and gastric upset during the whole period. At twenty-one she weighed 135 pounds, her best weight.

Her present weight was 117. She thought that there had been no recent loss.

Habits. Good, except that her sleep was only fair.

P. I. Four weeks ago she began to feel weak, somewhat as she did about a year ago when she had three months' treatment with arsenic for "anemia," with relief. Three and a half weeks ago she had excessive menstruation. During the past three weeks she had had heart attacks, sudden dizziness, and a sensation of falling, finally followed by a fall. She did not lose consciousness, but everything grew black. With each attack she had an eruption of giant hives. The second and third times she had eaten strawberries and haddock. The last attack was the day of entrance. It was not accompanied by such severe cerebral symptoms. Three weeks ago a tooth bled a little for several days. A week ago it bled for a day and a night, with formation of little clots. The day of entrance it bled also. Three weeks ago her legs became slightly swollen. Later there appeared some small purplish spots on the legs, some dark purple spots on the knees, and some black and blue spots on the arms. The latter had disappeared since the onset. There had been marked dyspnea on slight exertion and during the attacks of hives. For four weeks she had had ringing in the ears, and sounds of the heart action in her ears, especially when lying down. Her main symptoms were weakness, shortness of breath, attacks of dizziness with urticaria, and a hemorrhagic eruption, all of three or four weeks' duration. Three days ago she had transitory blurring of vision lasting a day. The day before admission this recurred, and still persisted. She thought her color was poorer than ever before.

P. E. Fairly developed and nourished. Skin brownish. Many small purple petechial hemorrhages and a larger subcutaneous hemorrhage on the lower legs, and one in the left deltoid region where she had received arsenic s. c. two days previous. Minute petechiæ on chest. Mucosæ pale. Bleeding from gums in two places, with a little clotted

blood. A few small anterior and posterior cervical glands of firm consistency. Bean-sized axillary and inguinal glands. *Chest* clear. *Heart* not enlarged. Action rapid. A systolic murmur heard over precordia, loudest in fourth space at left of sternum. Systolic *B. P.* 120, diastolic 55. *Abdomen* negative except that tip of spleen was palpable with deep inspiration. *Extremities*: Slight edema of legs. *Rectal* and pelvic examinations not done.

T. 98.8°-102°. *P.* 93-121. *R.* normal. *Urine*: Normal amount. *Sp. gr.* 1010-1022. Pale and cloudy at one of two examinations. A few leucocytes at one. *Renal function* 60%. *Blood Hgb.* 45% Tallqvist. Leucocytes 128,400. Polynuclears .5%-0. Lymphocytes 99.5% 73% small, 27% large (at a second examination 49% small, 50% large). Reds 2,080,000; showed moderate achromia and changes in size and shape at one examination, great variation in size and shape with many microcytes at a second. Platelets normal at one examination, diminished at a second. Wassermann negative. *Stools*: Fats in excess. Guaiac positive. *X-ray*: Hilus shadow increased on both sides. A few dense glands present. Lung markings and upper lobes somewhat thickened and beaded.

The patient was given the usual hospital diet with fluid extract of cascara 5 i, Russian oil 5 ss t. i. d., veronal gr. x or trional gr. x in the evening. Homatropin one drop was given in each eye June 9.

June 13 the patient became very dyspneic, with rising pulse and temperature. Late in the afternoon the temperature rose to 106°, the pulse to 140. The dyspnea was less marked. No cause was found. There was no localizing symptoms. Late in the evening she developed an urticarial rash, not relieved by adrenalin. June 14 she died.

CASE 6461.

DISCUSSION.

By DR. RICHARD C. CABOT.

NOTES ON THE RECORD.

I am always interested in necropsies that start off like this, where one knows that we have had a person who has been neurasthenic,

as we say "nervous," because we do not get necropsies in neurasthenia generally and because it is so common to read of supposed discoveries of the anatomical cause of neurasthenia. About once a year someone, usually a surgeon, discovers "the real cause." Necropsies like this tend to give us such check on these discoveries as we have. "Neurasthenia is due to ptosis." All right. Now here is an individual who apparently had neurasthenia and who died. It will be interesting to see whether she had ptosis. Neurasthenia used to be due to floating kidneys. We have got over that now. It used to be due to alimentary intoxication — the doctrine of Combe, the great Swiss. That has just blown away, not because it was disproved—there never was any evidence for it—but because it has gone out of fashion. Ptosis is the present fashion. I would be willing to bet that we shall not hear anything of it ten years hence.

This reads perfectly true for the description of what we call a neurotic type of patient.

We have had headaches before, and gastric upsets before, but until the last three months we have not had them steadily over a period. That is the first new thing.

"Bronchitis lasting several months" makes us wonder whether she had tuberculosis, another thing which has been discovered to be the "cause of neurasthenia."

The only special hint I get out of that past history that will help us is the question of tuberculosis.

Anemia in my experience is a rare disease. We say "anemia and neurasthenia" as if it were a tremendously common combination. But while neurasthenia is common, anemia is very rare. We look for something very definite and organic if a person has anemia. Maybe she had Bright's disease and was really anemic from that.

We have here a large group of hemorrhagic symptoms in the form of hemorrhage from the gum and purpuric spots on the skin. It is a very interesting point about dyspnea during the attacks of hives. Hives as we believe is a form of anaphylaxis. One of the

other forms of anaphylaxis is asthma, which apparently appear here (dyspnea) along with the hives, representing a protein intoxication which we now believe to be the cause of these things.

I expect to find her very definitely anemic as a result of all that has been said here.

Beans are of all sizes, but in this hospital the usual custom is to call a thing the size of a bean when it is about two to three cm. long. It is always an arbitrary question which glands that we can feel we will call enlarged. I think this size, two to three cm., is enough to constitute real adenitis.

From the chest examination it appears that the dyspnea and chest symptoms are probably not due to any disease of the heart or lungs.

All types of disease of the blood tend to give us enlargement of the spleen, so this does not surprise us.

The renal function is perfectly good.

With the blood examination the diagnosis is made. We have no more doubt what that is—it is a perfectly obvious diagnosis. Platelets diminished is exactly what one would expect with this type of leukemia. With the other type we should expect them to be increased.

The increase in the hilus shadows was presumably due to enlarged glands of the same type that were felt in the groins.

DIFFERENTIAL DIAGNOSIS.

She apparently died of an acute attack of anaphylaxis which we suspect like her other attacks to be due to protein intoxication, and we can well suppose were due to her own leucocytes, which break down and set free a good deal of protein in leukemia.

I do not remember having seen before anaphylactic attacks complicating leukemia.

A PHYSICIAN: I have a patient with myelogenous leukemia who has attacks of urticaria.

DR. CABOT: Perhaps you would look up this matter in the textbooks, because this point is entirely new to me. Either I never knew it or I have forgotten it. It seems reasonable with the evidence in the urine, the

increased uric acid due to the breaking down of the leucocytes, the nuclear bodies. It is perfectly reasonable that persons should poison themselves anaphylactically with that.

Only yesterday an indignant doctor from the West sent me a clipping from a local paper, in which some ladies who were trying to stop vaccination quote me as saying that expert diagnoses are fifty per cent wrong, that most doctors are not experts, and why should we trust the doctors to do anything? I get that about once in six months, because I once published here the actual "batting average" of myself and others of each disease, separately, not of all averaged together as people persist in doing. I said, There are certain diseases which we almost never get right, and there are others in which we seldom make a mistake. This is one of them. Our batting average is one hundred per cent in this disease. I do not think we have ever gone wrong, because we have an ante-mortem necropsy, we see the tissues. The essential tissue of the disease is in the blood and we see it during life. Anyone who has had any training cannot mistake this leukemic tissue, as it is seen in the blood, for anything else. Dr. Wright once took the trouble to take a leukemic blood clot and compare it with some of the leukemic tissues of the body. The leukemic blood clot was exactly like the leukemic tissues of the organs. Therefore when we see the blood we see the disease.

It is in these diseases that our diagnosis are one hundred per cent correct. When we see tubercle bacilli under the microscope we know the disease. We know typhoid fever because we get the organisms in the blood. We recognize pernicious anemia because of the characteristic blood picture, diabetes because it is a chronic disease with obvious and invariable symptoms. At the other end are pericarditis, right in one case out of five, and acute glomerulo-nephritis, pretty near the same average. I believe it is a good thing to publish these averages, so that we shall know what to expect and tell other people what to expect when our services are called for.

What will be found here? A slightly en-

larged heart, because that is the rule in leukemic cases. An enlarged spleen will be found, both from the physical examination and from general knowledge of this disease. A slight enlargement of the liver is quite probable. Enlarged glands in the mediastinum and along the front of the spinal column, corresponding to the mesenteric drainage. Subcutaneous and internal hemorrhages are quite probable, although she had not had a recent attack.

The marrow, if it is opened, should show that the red-cell-forming portions have been pushed to the wall by excess of lymphocyte infiltration. We know that because she has anemia. Leukemic cases do not become anemic until the marrow is invaded. If the disease stays in the glands they have anemia. If it invades the marrow they get anemia, and when they begin to get anemia we know that the end is not far off. I am watching now some cases of leukemia which are in perfect health, do not know they have it. They have never asked me and I have never told them. I was afraid they might look it up in a book. They have no anemia, and they are perfectly well. As soon as they get anemia I know the end will not be far off.

This was evidently an acute case, in which we have no therapeutics, in which X-ray, which helps chronic cases, is useless.

A PHYSICIAN: Is this type more malignant than the splenic type?

DR. CABOT: No. The most prolonged cases I have ever seen have been of this type. But it is commoner than the other type, and there are malignant types of each. But the longest cases we see are of this type too; so it has both extremes.

CLINICAL DIAGNOSIS

(FROM HOSPITAL RECORD)

Chronic lymphatic leukemia.

DR. RICHARD C. CABOT'S
DIAGNOSIS.

Lymphatic leukemia.

Hypertrophy of the heart.

Hypertrophy of the spleen and liver.

Hyperplasia of the bone marrow.

Subcutaneous and internal hemorrhages?

ANATOMICAL DIAGNOSIS.

1. Primary fatal lesion:

Lymphatic leukemia.

2. Secondary or terminal lesions:

Hyperplasia of mesenteric, retroperitoneal and bronchial lymph nodes.

Lymphocyte infiltration of bone marrow, spleen, liver, kidneys, pancreas and myocardium.

Hypertrophy of spleen.

Septicemia, staphylococcus aureus.

3. Historical landmarks:

Hemorrhagic areas of the skin and epicardium.

Edema of the lung.

Defective closure of the foramen ovale.

DR. RICHARDSON: The bone marrow was increased, in places brownish red, in other places a little grayish, on the whole rather soft, a little sloppy.

DR. CABOT: Was this patient a ptotic case? Were all the organs low in the pelvis?

DR. RICHARDSON: Not to my knowledge.

DR. CABOT: You remember we wanted to prophesy about that in relation to neurasthenia.

DR. RICHARDSON: Before making the section the lymph glands were felt to be slightly enlarged in the axilla, and in the inguinal regions from one to two cm. long. The bronchial glands were also enlarged up to three cm. and the retroperitoneal slightly enlarged—that is, a slight hypertrophy of the lymph glands generally.

The spleen was hypertrophied, weighing 350 grams—about twice its normal size.

The liver was a little heavier than usual. There was nothing remarkable in it except scattered reddish areas, with here and there small irregular grayish areas.

The kidneys showed a similar picture, only in the case of the kidneys the surfaces were dotted over with grayish areas, and they were seen in the section surfaces. That is, areas of lymphocytic cells scattered through the liver, spleen and kidneys.

The skin showed hemorrhagic areas, and there were some in the epicardium.

The heart was negative except that in the

myocardium some of the hemorrhagic areas on the endocardial side extended for a short distance into it, and there were in places a few of these same irregular small grayish areas—lymphatic increase, as in the other organs.

The gastro-intestinal tract was negative except that in the mucosa of the stomach there were a few hemorrhagic areas similar to those on the skin.

NEW AND NONOFFICIAL REMEDIES.

NEOCINCHOPHEN.—The ethyl ester of methyl-phenyl-quinolin-carboxylic acid. It was first introduced as novatophan. The actions and uses of neocinchophen are the same as those of cinchophen (New and Nonofficial Remedies, 1920, p. 224), only it is tasteless.

TOLYSIN.—A brand of neocinchophen complying with the N. N. R. standards. It is supplied in the form of a powder and as tolysin tablets 5 grains. Calco Chemical Co., Boundbrook, N. J.

SALIGENIN.—**SALICYL ALCOHOL.**—Saligenin is a local anesthetic, similar in action to procaine. It is said to be as effective as procaine but much less toxic; also the anesthesia produced lasts longer, and for this reason the addition of epinephrin is not necessary. Saligenin is a white solid soluble in water.

SALICAINE.—A brand of saligenin complying with the N. N. R. standards. Calco Chemical Co., Boundbrook, N. J. (*Jour. A. M. A.*, January 8, 1921, p. 113.)

ACNE BACTERIN MIXED NO. 10-BEEBE.—A mixed bacterial vaccine (see New and Nonofficial Remedies, 1920, p. 295) marketed in packages of six 1 c.c. vials, each c.c. containing 500 million killed *B. acni vulgaris*, 1,000 million killed staphylococci albi and 500 million killed staphylococci aurei suspended in physiological solution of sodium chloride; also marketed in 10 c.c. vials and in 20 c.c. vials. Beebe Laboratories, Inc., St. Paul, Minn.

ADALIN TABLETS 5 GRAINS.—Each tablet contains 5 grains of adalin (see New and

Nonofficial Remedies, 1920, p. 63). Winthrop Chemical Co., New York.

VERONAL SODIUM TABLETS 5 GRAINS.—Each tablet contains 5 grains of veronal sodium (see New and Nonofficial Remedies, 1920, p. 84). Winthrop Chemical Co., New York.

NOVASPIRIN TABLETS 5 GRAINS.—Each tablet contains 5 grains of novaspirin (see New and Nonofficial Remedies, 1920, p. 248). Winthrop Chemical Co. (*Jour. A. M. A.*, January 15, 1920, p. 179.)

PHENETSAL.—**SALOPHEN.**—The salicylic acid ester of acetaminophenol. The actions of phenetsal resemble those of phenyl salicylate (salol). It acts as an antirheumatic, antipyretic, antiseptic and analgesic. Phenetsal is white, odorless and tasteless. It is almost insoluble in water.

SALOPHEN.—A brand of phenetsal complying with the N. N. R. standards. It is supplied as powder and as Winthrop tablets of salophen 5 grains. Winthrop Chemical Co., New York.

SALOPHEN.—A brand of phenetsal complying with the N. N. R. standards. Morgestern & Co., New York.

CINCHOPHEN-CALCO TABLETS 7.5 GRAINS.—Each tablet contains 7.5 grains of Cinchophen-Calco (see New and Nonofficial Remedies, 1920, p. 225). Calco Chemical Co., Boundbrook, N. J.

PROCAINE-SQUIBB.—A brand of procaine (see New and Nonofficial Remedies, 1920, p. 29) complying with the N. N. R. standards. Procaine-Squibb is supplied as a powder, as hypodermic tablets procaine-Squibb $\frac{3}{4}$ grains, and as solution tablets procaine-Squibb $1\frac{1}{8}$ grains. Squibb & Sons, New York.

GLOBULES BENZYL BENZOATE-H. W. & D.—Each gelatin capsule contains benzyl benzoate-H. W. & D. (see New and Nonofficial Remedies, 1920, p. 49) 5 minims, diluted with olive oil. Hynson, Westcott & Dunning, Baltimore, Maryland. (*Jour. A. M. A.*, January 22, 1921, p. 245.)

TYPHOID COMBINED GLYCEROL VACCINE (PROPHYLACTIC)—**LEDERLE.**—A suspension

of killed typhoid bacteria (Rawling's strain), 50 per cent; killed paratyphoid bacteria, Type A, 25 per cent, and killed paratyphoid bacteria, Type B, 25 per cent, in a vehicle composed of glycerol, 66 per cent; physiological solution of sodium chlorid, 33 per cent, and cresol, 1 per cent. The product is supplied in packages of three vials containing the vaccine, and three vials of sterile diluent with which to make the proper dilution at the time of injection. For a discussion of the actions and uses of typhoid vaccines, see New and Nonofficial Remedies, 1920, p. 291. Lederle Antitoxin Laboratories, New York. (*Jour. A. M. A.*, December 25, 1920, p. 1783.)

BENZYL BENZOATE-VAN DYK 20 PER CENT. AROMATIC.—Each 100 cc. contains benzyl benzoate-Van Dyk, 20 cc.; oil of orange, 0.74 cc., and alcohol, 79.26 cc.

PNEUMOCOCCUS VACCINE No. 14-BEEBE.—A pneumococcus vaccine (see New and Nonofficial Remedies, 1920, p. 285) containing Types I, II, III and IV diplococci pneumonize in equal proportions, suspended in physiological solution of sodium chloride, each c.c. containing 500 million killed bac-

teria. Marketed in vials of 6 c.c., 10 c.c., and 20 c.c. Beebe Laboratories, Inc., St. Paul, Minn.

TYPHOID-PARATHYPHOID VACCINE No. 39-BEEBE.—A typhoid vaccine (see New and Nonofficial Remedies, 1920, p. 291) marketed in packages of three 1 c.c. vials, each c.c. containing 1,000 million killed typhoid bacilli, 500 million each of killed paratyphoid bacilli A and killed parathyphoid bacilli B, suspended in physiological solution of sodium chloride; also marketed in 30 c.c. vials. Beebe Laboratories, Inc., St. Paul, Minn.

TYPHOID GLYCEROL VACCINE (PROPHYLACTIC)—LEDERLE.—A suspension of killed typhoid bacteria (Rawling's strain) in a vehicle composed of glycerol, 66 per cent; physiological solution of sodium chlorid, 33 per cent, and cresol, 1 per cent. The product is supplied in packages of three vials containing the vaccine, and three vials of diluent with which to make the proper dilution of the vaccine at the time of injection. For a discussion of the actions and uses of typhoid vaccines, see New and Nonofficial Remedies, 1920, p. 291. Lederle Antitoxin Laboratories, New York.

PUBLISHER'S NOTES

THE MEAD JOHNSON POLICY.

Mead's Dextri-Maltose is advertised only to the medical profession. No feeding directions accompany trade packages. Information regarding its use reaches the mother only by written instructions from her doctor on his own private prescription blank.

ANESTHETICS COMPARED.

Comparing the local anesthetics most frequently used, in the current Yearbook of Anesthesia and Analgesia, Sollman finds procaine and cocaine equally as efficient for injection intracutaneously. Beta-eucaine is only one-half as efficient; quinine-urea one-fourth.

The showing is interesting so far as it goes, but further, when considering the two best anesthetics, one must know that pro-

caine is only about one-seventh as toxic as cocaine. Also, it is less irritating. That is why careful operators prefer it. As between the two, nobody mindful of the mishaps chargeable to cocaine, will hesitate a minute questioning which to use.

Procaine (introduced as novocaine by alien patentees) is now made by The Abbott Laboratories, Chicago. They offer both tablets and ready-prepared solutions in ampules. Those interested should write for a new 1921 price list now being mailed out by the company. An eighteen-page booklet covering the application of procaine in minor surgery is also available on request.

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An old adage says that "Truth is stranger than fiction." Has the reader ever stood near

one of our great railway arteries watching the passage of a heavily-laden cattle train? Has he observed how closely the animals, about twenty in all, are packed into each car? A trainload of sixty cars, 2,400 feet long, carries 1,200 cattle; and nine such trains, about four miles long, are required to transport 10,800 animals.

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ORIGINAL ARTICLES

PREVENTIVE MEDICINE AND THE TREND OF PRACTICE *

W. P. ADAMSON, M. D.
Tampa, Fla.

Sir William Osler, in the last year of his life, declared that the future of medical practice lay in the preservation of health—the prevention of disease. Preventive medicine, in its fullest meaning, consists of the elimination of deformity, disease and death in the antenatal and neonatal periods of existence.

The future of the race depends upon the child. Here preventive measures produce their most lasting and pronounced results. The intelligent co-operation of the public is a prerequisite to the successful application of preventive medicine. Mothers and fathers, then, must be taught how to co-operate, and the physicians in every community must be the teachers. Every physician, even though he practice some limited specialty, must be prepared to teach the fundamentals of motherhood and childhood. In the language of W. R. Ramsey, "The most fundamental part of every physician's practice is the care of mothers and children, and there is no part of his practice which will pay such high dividends in the future of the community and the nation, and if he does his work well, there is no reason why the annual monetary dividends should be passed unpaid.

"Any physician who neglects the best interests of the children entrusted to his care is not doing his best for his country."

The startling discovery that nearly one-third of the young manhood of the nation was unfit for military duty because of physical and mental defects, has served to focus the attention of all educated patriotic American citizens upon the source and origin of the trouble.

The Children's Bureau of the Department of Labor, created nine years ago, is doing an educational work limited only by the amount of the appropriation. There is no way to calculate the educational value of a sufficient appropriation upon the 14,000,000 children of continental United States under six years of age. One is led to speculate upon the subject, and to wonder how many young men fit for military duty might be saved to the country twenty-five years hence by an appropriation every five years equal to the price of one battleship.

It is estimated that there is an annual loss in the United States of more than 300,000 infants under one year of age, of whom at least one half could be saved if we, as individuals and communities, applied those measures of hygiene and sanitation which are known and available. This means neglect. It was once thought that a high infant death rate indicated a greater degree of vigor in the survivors. We now realize that the conditions which destroy so many of the youngest lives of the community must also result in crippling and maiming many others and must react unfavorably upon the health of the entire community. Sir Arthur Newsholme has said, "Infant mortality is the best index we possess of social welfare. If babies were well born and well cared for, their mortality would be negligible. The infant death rate measures the intelligence, health, and right living of fathers and mothers, the

*President's Address: Delivered before the Forty-eighth Annual Meeting of the Florida Medical Association at Pensacola, May 10, 11, 1921.

standards of morals and sanitation of communities and governments, the efficiency of physicians, nurses, health officers and educators."

The last year of which we have the statistics available, 1919, was the best year on record for the saving of infant lives. The average death rate of 269 cities was 87 for every 1,000 babies born alive and under one year of age. It is noteworthy that the mortality rate of different cities varies widely. The Berkeley, California, rate was only 44, that of Brookline, Massachusetts, 40, while 19 of the 269 cities gave a mortality rate of more than 120.

The records show that of the 87 babies per 1,000 who died under one year of age during 1919, nearly 50 per cent died before they were one month old. The progress made during the last twenty years in lowering the infant mortality rate has been due to improved methods of infant feeding, thus preventing diarrhoeal diseases and has been concerned chiefly with babies more than one month old. We are just beginning to learn that the deaths in this dangerous first month are no more necessary than those from diarrhoea and enteritis. They are due to conditions which have little or no connection with feeding, such as malformations, prematurity, birth injuries, and congenital weakness. The first month of infant life reflects ancestral and parental vitalities. The immunity of the baby depends upon the health of the mother. Alcoholism, syphilis, tuberculosis, uncinariasis, malaria, and all devitalizing and toxic processes show themselves in the lowered vitality of these early weeks. The obstetrician can do much by careful supervision during the months of pregnancy, to pass on to the pediatrician a healthy baby. This supervision is in most cases half-hearted and inadequate and does not extend even now to more than a small percentage of expectant mothers. The pediatrician can do much in his care of the baby to prevent nutritional disorders and hence deformities of the pelvis of future mothers.

Someone has said that children from one to five years of age are in the "No Man's Land of Childhood." Too little attention is given to defects arising here. Improper feeding, leading to malnutrition, is common. Habits of obedience or disobedience are established leading to the formation of character. The mother is either happy in the training of the child or helpless before his tirades. Like mother, like child. Many children grow up in poor physical and mental condition because of a lack of training—25 per cent of children reaching school age are sufferers from malnutrition. The tape measure and the scales should be used as freely as the clinical thermometer.

Among the causes of underdevelopment and malnutrition in this, the most impressionable period of childhood, one very potent for evil is a lack of maternal control. This evil, which happily is not very common, begins while the child is still in the cradle, and shows itself in irregular feeding, night nursing at an age when there should be none and the allowing of various unsuitable foods. The daily nap is dispensed with if the child so desires, and he retires to bed at 10 or 11 p. m. The nervous system suffers most from this lack of the stabilizing influence of authority. The child suffers the consequences in body and mind and character. The instability of the nervous system which develops in such a soil does not always disappear in childhood and may serve as the foundation for future mental disease. A helpless mother in the presence of a wilful child makes the doctor helpless and the problem well-nigh hopeless. At the very foundation of the question of developing the baby into a healthier, more useful man is early training. Some of the colleges for women are teaching their pupils how to take care of a baby, physically. The psychology of the child should be studied also, as being closely related to his training and physical development.

Less than fifty years ago the time was when the practice of medicine was compara-

tively simple. There was no science of bacteriology, no physiological chemistry, no serology, no roentgenology, no clinical microscopy. When an obstetrical patient died of sepsis, due to infection transmitted upon the hands of the operator (fresh from attending a septic case) the occurrence was satisfactorily disposed of by remembering that an all-wise Providence has power both to give and to take away. The best physicians were spoken of as "best-read" men.

Treatment was far in the lead of the science of medicine. Those were the days of the high topped hat and the Prince Albert coat. An air of mystery attended the person of the physician. The family physician reigned supreme in his locality. Within himself he carried his whole diagnostic and therapeutic outfit. These men were usually well educated, clear thinking, and self-reliant. The painstaking work of Marion Sims, of Montgomery, Ala., of Ephraim McDowell, of Kentucky, and of Crawford W. Long, of Georgia, may be mentioned as illustrating what could be done under difficulties.

Then came Lord Lister, who introduced his antiseptics, on a foundation laid by Pasteur opening the way for modern surgery. Through the work of Koch and others the science of bacteriology was soon an established fact. The Roentgen ray soon came upon the scene. The methods of diagnosis were changing. A new era was dawning. Our medical aspirant must not only be familiar with the literature, he must be a laboratory worker as well. Clinical microscopy in examinations of the secretions, of the excretions and of the blood; pathological discharges and new growths, had to be studied. Chemical analysis of the gastric contents had to be made. New methods of clinical examination were crowding to the front to demand their quota of the time and the effort of the already busy worker. The chemistry of the blood, functional kidney tests, functional tests of the thyroid gland, basal metabolism, studies in immunity and vaccine therapy

illustrate the nature of some of the recent ones. This rapid increase in the science of medicine, coming through a multitude of discoveries and the invention of innumerable methods, continues.

As the study and practice of medicine have become more complex, it has become more and more nearly impossible for one man to compass the whole subject—hence the specialist. A specialist is a physician who possesses "exceptional knowledge," or unusual technical skill in his chosen subject. The mere announcement by a physician that henceforth his practice will be limited to this or that branch of medicine or surgery does not make him a specialist. He must have spent years in the study of his chosen subject, and in practical work connected with it before he can reasonably lay claim to such a title.

It is agreed by the leading members of the profession that the practice of medicine is in a transitional state—that the work must be done, not by one mind, but by a group of minds, co-ordinating; that the family physician, the general practitioner, is passing away. However that may be, we already have group medicine. Every physician must secure for his patient such aids in diagnosis and treatment as scientific medicine demands. It is his duty, if practicable, to belong to a group of men who can supplement his own efforts at diagnosis and treatment. They need not have any business understanding to do this, nor need they occupy adjacent offices, but it is necessary that they have the spirit of cooperation.

Now, the problem is to create an arrangement by means of which every patient can get access to what he needs in the light of the most recent work in order that he may regain his health, and it is contented that unless we, as an organized profession, bring about some such arrangement, that state medicine will be thrust upon us and the unwary victims.

Dr. Victor C. Vaughan in a recent paper has outlined the needs of the physician and

patient and proposed a plan by which these needs may be met. The unit of his plan is the community hospital, open to all legally qualified physicians on an equal footing. Continuing, he says, "There must be a minimum of interference with the relation which has so long existed between the physician and his patient and which, on the whole, has been so satisfactory to both. The patient must have the right to select his physician, and the physician must have the right to study and prescribe for his patient as he sees fit. The pecuniary reward that comes to the physician must be determined between himself and the patient. There must be no state regulation in these matters. The panel system as employed in England is good for neither physician nor patient. There must be no state-appointed doctors to administer to the needs of those who are able to pay medical fees. I believe that any unnecessary interference with the voluntary and private relation existing between physician and patient would be detrimental to both."

Dr. Frank Billings, in a recent paper on "The Future of Private Medical Practice," has outlined a plan, which he calls the community health center, intended to fulfill all the needs of the sick and disabled and injured and to be administered by the local population, lay and professional, and not by the state.

State medicine which goes beyond its recognized field of sanitation, prevention of water pollution, food contamination and adulteration, the control of communicable diseases, etc., and enters the realms of treatment, save in exceptional circumstances, can find no rational grounds for its policy. All treatment measures should be left to the local profession which will then more freely cooperate with the sanitarian who need know little about them.

Compulsory health insurance is the product of class legislation and places its greatest burden on the medical profession, which it tends to degrade by robbing it of its freedom of conduct and enthusiasm for investigation.

MASOCHISM.

Case Report by

NEWDIGATE MORELAND OWENSEY, M. D.,
Atlanta, Ga.

The narration of the following case is done with the desire to impress upon the physician as well as the surgeon the importance of making a thorough study of the entire life of their neurotic patients, and not merely the study of the isolated symptoms of a given period. Had the anomalies of conduct and behavior of this case been studied from early childhood, an unnecessary operation would have been prevented.

The history of this case was furnished by the patient and corroborated as far as possible by her father.

White female, age 27 years. Occupation, student nurse. Referred by Dr. B.

Family History: Father, 65 years of age, living and healthy. Mother, 59 years of age, living, neurotic. One sister sixteen months older than patient; healthy. A maternal cousin is an epileptic; he married a maternal aunt of the patient; no offspring of this marriage. No other history of nervous or mental disease elicited.

Past History: The patient was a second child. During the entire pregnancy her mother was depressed and lachrymose. She subsequently informed the patient that she was not wanted when born. The delivery was normal in all respects. During the first two years of the patient's life she vomited her food and had convulsions every day. This condition was attributed to the use of condensed milk and ceased when the milk was withdrawn. She walked shortly before the expiration of the second year, but did not speak until some months later. Her father states that she had a very bad temper at an early age and would bump her head against the floor when irritated.

Between the second and seventh years she had some trouble with earaches, enlarged tonsils and swelling of the glands of the

neck. The glandular enlargement subsided later without an operation. She also had measles, whooping cough and chicken pox during this period.

From the seventh to the sixteenth year, the patient states that she was a perfectly healthy, tomboy type of a girl. That during this period she and her sister had several fights in which she thought her sister to be the aggressor. At these times she would often bite her sister and would be punished by her mother. Her sister always escaped punishment, which led her to believe that her mother was decidedly partial to the sister.

During her sixteenth year she became deeply infatuated with one of her boy friends and was particularly anxious to marry him at the time. Her mother broke up the affair, however, and insisted upon her returning to school. She corresponded with this youth and saw him during her vacations until her eighteenth year when he married one of her girl friends. She denies any sex relationship with this sweetheart. She seemed to think that her mother had some ulterior motive in breaking off this affair, and has been very resentful towards her since that time. She threatened to run away from home on account of this affair, but was finally persuaded not to do so.

She finished school during her nineteenth year and began teaching a kindergarten in a nearby town. According to her statements, she was very fond of children and succeeded well in her work.

During her twenty-first year she had her tonsils removed without informing her parents until after recovery from the operation. Shortly after this she inflicted a wound on her side by saturating a gauze bandage with tincture of iodine and a solution of bichloride of mercury and strapping it to her skin. Immediately after inflicting this wound, she began masturbating. Shortly after recovery from this wound, she intentionally cut her hand and placed a foreign body in the cut to prevent its healing. A few weeks later she stuck an invisible hairpin underneath the

skin of her arm. Following this self-inflicted wound she slept for five days without awakening. During the next three weeks she slept from one to three days without awakening. Two weeks later she swallowed several bichloride of mercury tablets which were subsequently removed without doing very serious harm. She states that she did not swallow these tablets with suicidal intent and notified her parents immediately following the act. During the following year the patient inflicted six wounds on her body and arms by sticking needles into herself and then breaking them off.

In September, 1917, she entered the training school for nurses in Roosevelt Hospital, New York. She states that she enjoyed her work and did not inflict any wounds on herself for the next twenty-five months. At the expiration of the last month she became somewhat exhausted from overwork and was given a vacation for thirty days. Shortly after her return she administered an overdose of medicine to one of the patients. She claims that this was an accident and substantiates same by letters written by one of the internes. She was expelled for this offense, however, just eight weeks before her class graduated. Upon her return home she informed her parents that she was ill and failed to make any reference to having been expelled. A day or so later she inflicted another wound upon her body. Immediately following this wound she had an attack of vomiting which lasted four days. This was the first attack of continuous vomiting since early childhood.

In November she entered the training school for nurses at St. Vincent's Hospital, Bridgeport, and worked there continuously until January, 1920, when she had an attack of vomiting lasting ten days. She then returned to duty and worked for two weeks when she was forced to go to bed on account of laryngitis.

The latter part of April, 1920, she inflicted a wound on her left thigh, just above the knee. She accomplished this by burning the

skin with tr. iodine and inserting a foreign body underneath the skin. She dressed the wound herself and let the dressing remain until "it had burned enough," then she called the house physician's attention to it. Was off duty two days on account of this. She failed to inform the physician of the foreign body in the wound and it drained until the latter part of May when he was told of its presence. Erysipelas followed this wound, but lasted a very short time. After recovery from the erysipelas she had an attack of vomiting lasting eight days. She was then sent to the Neurological Institute in New York for observation. She remained there one week and upon the advice of her physician she came South to visit relatives in July, 1920. After coming here she decided to do private nursing. After leaving her first case she returned to her relatives' home and slept for eighteen hours. Upon awakening an attack of vomiting occurred which lasted seven days.

On September 10, 1920, she had an attack of vomiting following a four hours' sleep. Another attack of vomiting occurred on September 17th, in which a small amount of blood appeared. She was removed to St. Joseph's Infirmary, Atlanta, where she remained five days before the vomiting ceased.

She entered the training school for nurses in one of the Atlanta hospitals in November, 1920. Her work was agreeable and she was contented until December 14, 1920, when she contracted a very severe headache which was followed by nausea and vomiting. Large quantities of blood was expelled at this time. An X-ray examination was made at this time, and as a result of the findings, an exploratory operation was made on December 28, 1920. No pathological condition was found in the viscera and the wound was closed.

The patient states that she had sufficiently recovered from the operation on January 12, 1921, to walk about her room without discomfort. She began vomiting again on January 16th, and continued to do so until Janu-

ary 29th. At that time I was requested to make a neuropsychiatric examination of the patient. As a result of my examination the patient was discharged from the hospital and sent to her relatives' home, and requested to report at my office the following day for further examination. No dietary restrictions were made and the patient was advised to eat as much substantial food as possible.

Upon reporting at my office the following day, the patient informed me that she had dined upon beefsteak and onions the evening before without observing any ill effects.

Physical Examination: Face covered with what appeared to be a bromide acne. Body fairly well nourished despite the inability to retain food or liquids for such a long period. Viscera normal. No evidence of pathological condition existing.

Neurological Examination: Negative, except for slight inequality of knee jerks.

Psychiatric Examination: The patient presents an unusually many-sided problem. There is absolutely no doubt of a fundamental difficulty or handicap, as shown even roughly organically in the inequality of the knee jerks. The whole development of the young woman has unfortunately been very incongruous, and the succession of disappointments has led to a ruminative tendency in which the patient asks questions like these: Why did her mother always show partiality to her sister instead of treating each the same? Why did she break off the one love affair of her life and prevent her from enjoying the bliss of a married life and the rearing of a family? She admits that she was very young at the time and needed a better education to cope with the problems of life, but she cannot help but think that her mother had some ulterior motive in preventing her marriage. She states that for the past five or six years her mother has shown her all the tenderness and affection possible, but she insists that she despises her. On the other hand she claims to be extremely fond of her father, although he has paid very little attention to her in the past.

She denies ever having had sexual intercourse, but admits practicing masturbation which begun immediately after the first self-inflicted wound. She claims that her sexual desires are intensified whenever a member of the opposite sex pinches her arm or inflicts pain in any way. She states that several of the self-inflicted wounds followed associating with a girl friend who had a habit of tickling her. No evidence of homosexuality could be elicited.

When questioned regarding the self-inflicted wounds, she could give no clear or comprehensive reason for them. She states that she knew perfectly well what she was doing at the time, but despite this fact she made no effort to prevent herself from doing so. The reason attributed for placing the foreign bodies in the wounds was because of the fact that they caused infections and she liked the throbbing sensation which followed.

In discussing her history she showed a great deal of spontaneity, plunging right into the middle of the subject and going over her history in considerable detail. Her mood was one of eagerness without any definite elation or depression. Although her narrative was at times redundant, prolix and rather confused, there was no maniac distractibility; memory and intellectual functions showed no defect and she grasped the test story promptly.

She gave an account of her unsuccessful career as a nurse without any insight into the fact that her constitutional features were at the basis of her difficulty.

Although she has obviously had considerable friction with her mother, there were no paranoic elaborations; her reactions apparently are merely general abuse and depreciation of her mother.

The patient is of an introverted type of personality, and repressed her desires and feelings as much as possible. The breaking off of her early love affair influenced her to repress her affective cravings for seeking those healthful outlets which constitute the

behavior of the normal girl. Her sexual cravings thereby became forced to seek gratification through means which were perverse, and in this case became masochistic. It is possible that she stumbled on the knowledge that pleasure could be derived from pain when she had her tonsils removed. Then, too, it afforded an opportunity to revenge herself upon her mother by forcing her to spend money which she could ill afford. When her ambition to become a nurse had been thwarted, the cravings reverted to the more simple infantile condition of emesis, as well as an attempt to compensate for her inability to succeed in her profession. The long periods of sleep were doubtless due to an inferiority complex, coupled with a desire to forget her disappointments.

The vomiting of blood may have been due to a self-inflicted wound of the throat, since no evidence of an ulcer was found when the exploratory incision was made. Unfortunately the examiner failed to ask the patient to give her explanation for this condition. The X-ray findings can only be attributed to the fact that some scar tissue was formed at the time the bichloride of mercury tablets were swallowed.

My impression is that the case presents a well-marked mental instability or constitutional psychopathic inferiority, and that the masochistic behavior and periodical attacks of vomiting are secondary to this condition.

The prognosis of this case depends largely upon environment. The patient should be placed where the surroundings are cheerful and she could indulge in the out-door sports—something on the order of a girls' camp. Matrimony would perhaps have a tendency to decrease the masochistic cravings, but on account of the danger of defective offsprings is not to be advised. The attacks of vomiting will probably return whenever the patient experiences a disappointment or becomes unduly depressed.

710 Peters Building.

Read before the Fulton County Medical Society, Atlanta, February 17, 1921.

CASE RECORDS.*

(ANTE-MORTEM AND POST-MORTEM) AS USED IN WEEKLY
CLINICO-PATHOLOGICAL EXERCISES AT THE
MASSACHUSETTS GENERAL HOSPITAL
EDITED FOR THE USE OF PRACTITIONERS BY

RICHARD C. CABOT, M. D., AND

HUGH CABOT, M. D.

F. M. PAINTER, ASSISTANT EDITOR

CASE 6322

An American baby girl of three entered December 22 for relief of fever and cough.

F. H. Good.

P. H. The baby was normal at birth and was breast fed for 8½ months at quite regular intervals, then gradually weaned to whole milk. Cereals, gruels, soft toast, etc., were gradually added to the diet. As an infant she had occasional colds, but none of the diseases of childhood.

P. I. Seven days ago she developed an attack diagnosed as bronchitis and possible measles. Four days ago the temperature was 106° and the cough seemed a little worse. Her appetite was poor and her bowels quite constipated. That evening she passed a very dark, rather soft stool. From this time until admission she grew progressively pale, irritable and restless. The morning of admission the doctor noted very marked pallor. The temperature was 102°. A small black and blue spot was noticed on the forehead and another on the sacrum. Their duration or cause could not be explained. She had eaten practically nothing since December 19, but had drunk large amounts.

P. E. A very well developed and nourished girl, restless, rather irritable, and looking extremely waxy and acutely ill. Skin: Extreme pallor all over mucous membranes. An ecchymosis about the size of a quarter dollar on the forehead. Apex beat of heart on percussion located in 5th space 7.5 cm. to the left of midsternum and 3 cm. outside the nipple line. On palpation the heaviest impulse was felt 5 cm. to the left of midsternum and 2 cm. inside the nipple line. Right border

2 cm. to the right. Action very rapid. Loud blowing systolic murmur heard all over precordia, best over the mitral area, transmitted to the left and right and through to the back. Sounds of good force. *Lungs*: No appreciable dullness except at the right base, and this probably liver. A few crackles, not constant, over both right and left back. Small areas of bronchovesicular breathing. Over left apex in front a small area of bronchial breathing. Voice much increased. *Abdomen*: Liver palpable 2 cm. below costal margin. Edge soft. Slightly enlarged spleen, soft and tender. *Genitals, buttocks, rectal examinations, extremities and pupils* normal. *Reflexes*: Knee-jerks and abdominals present.

T. for the first four weeks 99.7°-103.2°. January 19-25 there was a wave of elevation, 100° to a maximum of 105.8° January 22. January 26-February 1, 100°-102.3°. Then until death elevated, 100°-106.5°. *P.* 108208. *R.* 16-58 until four days before death, then 45-81. *Urine*: Sp. gr. 1016 at the one satisfactory examination. A few to occasional leucocytes at 8. *Blood*: Hgb. 35%-40%. Leucocytes December 22-27, 16,000-20,000. December 30-31, 11,000-13,000. January 2-February 11, 4,200-9,200. Polynuclears 43%-62%. Reds 1,500,000-2,000,000. Slight poikilocytosis and anisocytosis. 2%-4% transitionals. 2%-3% normoblasts at 2 examinations. 1 macrocyte at one examination. Platelets questionably decreased at one examination, normal at five, decreased at 3. Considerable to slight achromia at 4 examinations. *Stools*: Chocolate brown at 3 of 17 examinations, black at 3. Mucus at 8 of 17 examinations, 3 times in large amounts. Blood at 4; guaiac positive at 2 others.

The child was put on a milk diet with an ice bag to the precordia. Water was forced. She was given 3 minims of tincture of digitalis every three hours for three doses and syrup of hydriodic acid 5 s. s. t. i. d. Paregoric was prescribed in ten-minim doses every 4 hours p. r. n. for restlessness. The diet was extended to include orange juice, cereal, broth, soft toast, custard, junket and milk. December 24 she was given 70 c. c. of

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citratized blood subcutaneously in the buttocks. Two days later her color was perhaps a little better. She was fretful and at times seemed almost delirious, although she talked quite rationally. Codein sulphate was given in 1/12 grain doses every 3 hours p. r. n. for cough. December 28 she looked much better. The temperature ranged about 101°, but the variations were not so marked. She complained a great deal of cough. December 29 there were superficial crackles, muffled voice sounds and moderate dullness over the left base posteriorly. The liver dullness extended nearly to the level of the umbilicus. The heart examination was difficult, but there was a questionable presystolic murmur in addition to the systolic heard at admission, making it a to-and-fro murmur with the remains of the first sound intervening. December 30 the temperature was down and there was no more blood in the stools. The abdomen was distended and tympanitic, and worse. The fluid seemed to accumulate. January 1 the spleen was 3½ fingers below the costal margin. The cough was improved. January 3 the heart rate was much slower than at admission. January 5 the abdomen remained distended. Fluid wave was present, with shifting dullness in both flanks. The inguinal and umbilical herniae were growing worse. The fluid seemed to accumulate. January 11 the left border of the heart was 8 cm. from midsternum, the maximum apex beat 7½ cm. There was a systolic and presystolic murmur heard best over the mitral area. The abdomen was not quite so distended. Two days later the general condition was decidedly better, though the anemia was no better. The ascites was gradually disappearing. January 18 on palpation it was noted that the mass in the right upper and right lateral quadrants had diminished in size, while the one in the left upper and left lateral quadrant had increased. There was also a definite nodular growth extending from this latter mass toward the midline which had not been palpable before. There was also an indefinite nodular mass in the lower part of the right lateral and the upper part of the right lower

quadrant. These masses were present after a high enema with good results.

January 19 transfusion of 60 c. c. by the citrate method was done. Two days later the patient was bright and wanted to sit up. The abdomen was distended with gas. January 22 there was unexplained rise of temperature, pulse and respirations. The child was rather fretful, requiring paregoric, sponges and colonic irrigations. January 23 electrocardiogram showed sino-auricular tachycardia (rate 160); no auricular hypertrophy or ventricular preponderance. January 23 she was a good deal better. The temperature was down to 102.2°, the respirations to 30, the pulse to 140. The night of February 1 the temperature, pulse and respirations took another unexplained jump. The abdomen was quite distended with gas. A warm rectal irrigation and warm abdominal applications gave great relief. February 3 the temperature was down to 100°, with a corresponding drop of pulse and respirations. The child continued to be very fretful. During the next two days the temperature was high, 101°-104°. The morning of February 5 she had five tarry stools with positive guaiac. She complained of thirst, and drank large amounts. The mass in the left upper quadrant had extended beyond the median line and out to the axillary line. The following morning she vomited a large amount of clotted bright red blood and afterwards vomited three times more. Enough morphia was given (3 1/32 gr. doses) to control the restlessness partially. Continuous proctolysis of 5% glucose was started. During the following 24 hours 1000 c. c. was retained. That night 200 c. c. of blood was transfused by use of a Kempton tube. The child was much brighter and had a better color. The pulse dropped 30 beats. She lost a good part of the blood transfused. February 7 the condition was not so favorable. The pulse was running from 180 to 190 and she was very restless. She was given cracked ice to suck, and the continuous rectal drip was repeated. She failed very rapidly, retained nothing by mouth and very little by rectum. February

9 she took some nourishment by mouth for the first time in three days, retained it, and had a very comfortable night, though she passed one tarry stool. February 12 examination of the lungs showed general roughening and harshness of breath sounds, with a few scattered rales all over. There was marked cyanosis. The temperature was a little lower. That day she died.

CASE 6322

DISCUSSION.

BY DR. FRITZ B. TALBOT

NOTES ON THE RECORD

It is worth noting that this illness developed in the winter.

When we get an apex beat outside the nipple line in a child of three it means either that the heart is pushed to the left or that the heart is enlarged. "Right border two cm. to the right" means that the heart is not pushed over, but is enlarged, and the diffuse apex beat points to dilatation rather than hypertrophy.

The white count does not show any marked reaction consistent with the great elevation of the temperature. The polynuclears were 43 to 62 per cent. The record does not say how long it took for the increase to come, but from January 19 to 28 there was a change from a normal differential count of forty-three per cent. to a polynuclear leucocytosis in which the polynuclears overbalanced the mononuclear cells. This is abnormal at the age of three years.

This case, so far as we have gone, looks like a typical case of acute endocarditis with more or less general infection, with the hemorrhages that sometimes come with a malignant endocarditis and the anemia which practically always comes with it. The enlargement of the spleen is also consistent with a general septicemia. The examination of the blood shows a secondary or a simple anemia, which can be explained by the infection; the presence of normoblasts is an indication of some attempt to repair. The blood in the stools, unless it is explained in

the same manner as the subcutaneous hemorrhages, I cannot explain.

Evidently the anemia was so great by December 24th that it was necessary to try to stimulate the formation of blood.

The findings at the left base posteriorly are very difficult to interpret, at times, when the heart is enlarged to the extent that this one appears to be. The measured enlargement that we are able to make by percussion is a lateral enlargement, and there must be also an enlargement in the direction of depth as well. This widening of the heart in the anterior-posterior diameter can be so great that it compresses the lungs in the left base, and this gives symptoms which are indistinguishable from those of an early pneumonia with the temperature and the crackles. With the signs present it is very difficult to say whether a pneumonia had started at the left base or whether they were due merely to compression. Probably they were due primarily to compression with an infection of top of it.

The question comes up at the time of the examination of December 30 whether the infection which we assume was present had extended to the liver to such an extent as to cause this great engorgement of the liver and obstruction to the portal veins, thus causing enlargement of the superficial veins, or whether there was breaking compensation. Probably it was the latter. In the fluid wave and shifting dullness we again have evidence of broken compensation.

DIFFERENTIAL DIAGNOSIS

This is a very complicated case, and it is rather difficult to sum up. In the first place we have infection and apparently general septicemia. In the second place we have signs referable to the heart which can be explained best by a general endocarditis with dilatation and breaking compensation. And the secondary anemia can very well be explained by a malignant endocarditis.

Up to that point the case seems fairly simple, but when we come to discussing the abdominal findings, they are not consistent

with the original diagnosis, and it is hard to explain why these masses should appear in the abdomen. Nor does the great amount of hemorrhage that this child had fit in very well with the endocarditis and septicemia alone. So that something must have happened in the last part of her stay in the hospital which is different from what she came in with first. The only thing I can say that is perfectly consistent, and it is a very rare thing, is thrombosis of some of the mesenteric vessels, thus causing the loss of blood from the bowels and the local physical signs. But that is really a guess rather than anything that can be inferred from the physical examination.

There was either some infection of the lungs or the break in compensation explains the symptoms which we regarded as referable to the lungs. Can you explain the masses and hemorrhage, Dr. Young?

DR. YOUNG: No. I do not believe it could be thrombosis and hemorrhage three weeks after it. She did not die until February 12, and these things were noted the middle of January.

DR. TALBOT: I think in the first place the enlargement of the liver and spleen could be explained by the general septicemia and break in compensation of the heart. That first mass was probably the liver. Then we began to get irregular masses. The same data were noticed on January 18.

CLINICAL DIAGNOSIS

(FROM HOSPITAL RECORD)

Malignant growth in abdomen.

DR. FRITZ B. TALBOT'S
DIAGNOSIS

General septicemia.

Acute endocarditis.

Thrombosis of mesenteric vessels.

Hypertrophy and dilatation of the heart.

Secondary anemia.

ANATOMICAL DIAGNOSIS

1. Primary fatal lesion:

Thrombosis of the portal vein and its great radicles.

2. Secondary or terminal lesions:

Passive congestion of the spleen.

Ascites.

Hypertrophy and dilatation of the heart.

Edema of the lungs.

Anemia.

Operation wound, right thigh.

DR. RICHARDSON: After the masses were noted were they succeeded by hemorrhages?

DR. TALBOT: There were hemorrhages before and after the masses were noted.

DR. RICHARDSON: Then did they disappear after the hemorrhage? Are they mentioned again?

DR. TALBOT: I do not think so. There is no note of those masses disappearing.

DR. RICHARDSON: There is no note of their staying, is there? They apparently did not attract attention enough to make a note of it.

DR. TALBOT: So that, on the basis of that argument, the masses might have been fecal material that was got rid of?

DR. RICHARDSON: Yes, or hemorrhage.

This is a case of thrombosis of the portal vein and radicles. The intestine in this case is interesting, especially in association with the clinical facts. The stomach mucosa was very pale and the pylorus negative. The intestines were very pale and the mucosa negative. The other organs showed pallor of the tissues. Anatomically there seemed to be some anemia present.

The heart was slightly enlarged, the valves negative. There was nothing in the lungs. The kidneys were a little large, but macroscopically and microscopically negative. The only lesion in the case was the thrombosis of the portal vein and its radicles.

This was of course a very unusual case. Presumably the pallor of the intestines was due to hemorrhages. The intestines having become engorged bled out. Usually in thrombosis of the portal vein and radicles we should expect more or less of an engorged condition of the intestinal walls, known as hemorrhagic infarction. The thrombosis was frank both macroscopically and microscopically.

We were not permitted to examine the head.

The spleen showed passive congestion, and the cutaneous vessels were well marked.

There was about 500 c. c. of thin pale clear fluid in the peritoneal cavity, and some edema of the lungs.

The cause of thrombosis of the portal vein in many cases we do not know, but in a general way it is associated with infection.

Going back a step, thrombosis of the portal vein and radicles may occur in typhoid fever. But eliminating infections we come to those cases where anatomically we cannot tell what the phlebitis was due to.

DR. TALBOT: Did you get any culture?

DR. RICHARDSON: No. In this case we could make only an abdominal section, and so no culture was obtained. There might have been an infection.

The thymus gland was very small, but otherwise negative.

PROPAGANDA FOR REFORM.

DIGIFOLIN NOT ADMITTED TO N. N. R.—Digifolin-Ciba is a product of the Society of Chemical Industry of Basle, Switzerland. It is claimed to be "a preparation of digitalis leaves, that has been freed from their useless and harmful principles such as digitonin (saponin), coloring and inert matter, etc., but does contain all the really valuable and therapeutically active constituents of the leaves; namely, digitoxin and digitalein in their natural proportions. The Council on Pharmacy and Chemistry reports that there is no evidence that digifolin contains all of the glucosides of digitalis as they exist in the leaf and that it is extremely improbable that this is the case, because one cannot remove the saponin without altering the other active principles of digitalis. The Council also held unwarranted the claim that digifolin does not have the disadvantages of galenical digitalis preparations since it is well established that the untoward effects of digitalis

are inherent in the principles that exert the desired effects of digitalis and that these may be avoided largely by a carefully regulated dose of any digitalis preparation. The claim that Digifolin-Ciba has all the advantages and none of the disadvantages of digitalis has been refuted so frequently that manufacturers must be aware that it is untenable. Further, the report concludes, the claims now made for digifolin are essentially those made nearly four years ago, at which time the attention of the American agent was called to their unwarranted character. (*Jour. A. M. A.*, April 2, 1921, p. 952.)

HEXAMETHYLENAMIN AND SODIUM ACID PHOSPHATE. — Hexamethylenamin acts in acid urine only. Hence, if the urine is not acid, sodium acid phosphate should be given in doses of 1 to 2 gm. midway between the doses of hexamethylenamin. Enough of the sodium acid phosphate should be given to render the urine acid, but not enough to cause diarrhea. (*Jour. A. M. A.*, April 9, 1921, p. 1031.)

MORE MISBRANDED NOSTRUMS.—The following preparations have been the subject of prosecution by the federal authorities charged with the enforcement of the Food and Drugs Act, on the ground that the therapeutic claims made for them were false and fraudulent: *Treatamiento Zendejas* (Panfilo Zandejas), a solution containing potassium iodid, plant extractives and sugar. *Helmitol* (Bayer Co., Inc.), tablets consisting of hexamethylenamin, methylencitrate and talc. *Self-help E. and I. Treatment* (Henry S. Wampole Co.), consisting of a liquid which was essentially zinc chlorid and glycerin and tablets containing cubebs, copaiba balsam with small amounts of santal oil, alunm and magnesium oxid. *Uriseptic Pills* (G. J. Fajardo), consisting essentially of hexamethylenamin, cubebs, santal oil and kava kava. *Pinkolo Ointment* (Custer Chemical Co.), an ointment containing camphor, red mercuric oxid and zinc oxid. (*Jour. A. M. A.*, April 9, 1921, p. 1029.)

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THE PENSACOLA MEETING.

The forty-eighth annual meeting of the Florida Medical Association, and the second annual meeting of the Florida Railway Surgeons' Association held in Pensacola May 9, 10, 11, have passed into history. By those in attendance they will be remembered for many years to come as one of the pleasing memories of association affiliations. Pensacola outdid herself. The Committee on Arrangements had all details for the comfort and welfare of their guests well in hand from the moment of arrival to the time of departure. The meeting was well attended and interesting, scientific programs were presented—all in all it was a most delightful occasion. Time does not permit a more extended notice of the meetings in this issue. The June number of THE JOURNAL will however contain a complete record of the transactions of both organizations. G. E. H.

THE STUART BILL.

The Stuart Bill, providing for a Composite Board of Medical Examiners, has passed the House with a very comfortable majority. As THE JOURNAL goes to press we learn that the Senate Committee on Public Health has reported the bill out favorably, making only some minor amendments which were agreed to in committee by our own Committee on Legislation and Public Policy. As stated in our April issue, minor differences of opinion must be put aside, having only in mind the passage of a law that will at least be an improvement of present conditions. The fight which has been going on for many years may be said to have been won, for with a favorable committee report, the only opponent to the measure is the little old fellow that waits for no one, "Time." All efforts for the past few days have been directed toward getting action in the Senate. The various civic bodies throughout the State have come forward with a helping hand, never before have we been able to put up such a solid front. The day of the fakir and men of low professional standard are now numbered. In our next issue we feel confident that we will be

able to present to our readers the text of a new Medical Practice Act that will redound to the credit of those who have worked so hard and so faithfully for the past many years.

G. E. H.

THE LETTER BOX

COOPERATIVE MEDICAL ADVERTISING BUREAU

*Under the Auspices of the American
Medical Association*

535 North Dearborn Street

CHICAGO, May 10, 1921.

*Dr. Graham E. Henson, Journal of Florida
Medical Association, Jacksonville, Fla.:*

DEAR DOCTOR HENSON—We congratulate you on your excellent April issue. It is an attractive number in every way.

Especially does your printing company deserve special commendation, and you are at liberty to refer this letter to them, if you care to do so. The evidences of a good printer are shown nowhere more quickly than in the quality of ink used and their press work. The way in which the cuts show up in your sanitarium advertisements makes your JOURNAL distinctive. Advertisers especially will appreciate your consideration of them.

If you can afford to maintain this quality of paper, and your printers will exercise the same care in future issues as in the April number, the Bureau can get more business for you. This JOURNAL itself is the best evidence of the Record Printing Co.'s statement on the fifth page of this number. It ought to get them business from Florida physicians. The Record Company ought to use your mailing list to solicit printing from your readers.

We hope you had a successful state convention.

Very truly yours,

COOPERATIVE MEDICAL ADVERTISING BUREAU.

E. W. MATTSON, *Manager.*

[THE JOURNAL has not been all that it should have been during the war and post-armistice days. As mentioned in at least two annual reports of the editor and on several occasions in the editorial columns, the reasons there-

fore hardly needed an explanation. With fifty per cent of the members of the Association in the Government services, these absentees probably representing at least seventy-five per cent of those contributing scientific material for our reading pages, the publication was necessarily hard put for worth-while reading matter. Not only this, but the increased cost of publication resulted in insufficient funds to produce our pre-war thirty-two-page reading form. We therefore had to retrograde. The increase in state dues provided for at the forty-seventh annual meeting were not available until recently. It is pleasing, therefore, with the appearance of our April number, more nearly approaching our pre-war standard than any number published in four years, to receive the above letter of commendation from the Cooperative Medical Advertising Bureau. The editor of a scientific publication is charged with two duties—one to satisfy the readers, the other to satisfy the advertiser. The scientific pages of THE JOURNAL can be made as valuable to the Florida profession in just that proportion that the profession are willing to contribute to its pages. From a business standpoint, THE JOURNAL has arrived; from a scientific one its future depends upon the willingness of the Florida profession to contribute articles of merit.]

WAR DEPARTMENT

VICTORY MEDAL OFFICE

Masonic Temple, Jacksonville, Fla.

TO THE EDITOR:

Now that recruiting for the U. S. Army has ceased, the War Department is very desirous that the officers left in charge of the Victory Medal work make special effort to reach all the ex-soldiers or the next of kin of deceased soldiers in order that they may receive the medal that is due them.

The distribution of Victory Medals in Florida began last June with the headquarters at Jacksonville and to date nearly 2,000 medals have been issued in this state which is a very small number considering the population of the state of Florida and the

number of soldiers she gave during the World War.

This medal, which is a work of art, is awarded to all soldiers who served at any time from April 7, 1917, to November 11, 1918. To those soldiers who did not get a chance to cross the sea but who gave honorable service in the United States, a plain Victory Medal is awarded without any clasps on the ribbon. To those who went overseas but did not participate in any battles the words "France" appears on the ribbon, and to those soldiers who fought on the various battle-fronts the name of each battle they participated in is written on a clasp and placed on the ribbon of the medal. As many as five battle clasps have been awarded to Florida soldiers.

The medal is made of heavy bronze, on the face of which is a Winged Liberty with drawn sword but in an attitude of peace. On the reverse side is written the words: "The Great War for Civilization" and the names of all the allies, "France, Great Britain, Belgium, Italy, Serbia, Brazil, Montenegro, Russia, Greece, Portugal, Rumania, Japan and China," while an appropriate insignia of the United States appears in the centre which signifies: "Unity is Strength." The colors of the ribbon embraces all the hues of the rainbow bordered by a white line which means the dawn of a new era of peace.

Ex-service men or next of kin may apply in person, may phone this office (1121), or may send a post card and the proper forms will be mailed them to be filled out, or you may fill out the following coupon as directed and mail:

Victory Medal Officer, Jacksonville, Fla.:

SIR—Please send me a Victory Medal application blank. I served in the United States Army during the World War as an..... (state whether officer or enlisted man).

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WOMEN OF THE PUBLIC HEALTH SERVICE.

In proportion to its size, the personnel of the U. S. Public Health Service probably includes more highly trained and specialized women than any other branch of the Federal Government.

Highest on the list stand two officers holding commissioned rank in the reserve — Surgeons Lydia Allen DeVilbiss and Josephine Baker. Next in rank came a number of scientific and professional women, all or most of whom are physicians, though some are classified by other titles. Among these are acting assistant surgeons Blanche Sterling and Edith B. Lowry, Viola Russel, pediatricist, and Elizabeth B. Reid, all of the child hygiene section; Ida A. Bengtson, sanitary biologist; Alice C. Evans and Mrs. E. M. A. Enlows, bacteriologists; and Mrs. S. C. Brooks, assistant biologist, all of the Hygienic Laboratory; Gertrude Seymour, president of the American Women in Public Health, and Drs. Daisy Robinson and Edith Rabe, regional consultants, all of the venereal diseases division.

Several large groups of highly trained women have been organized in the Public Health Service. Among these are the reconstruction aids, most of whom have had college training or its equivalent and all of whom are of unusual ability and character. These are stationed at various hospitals of the Service throughout the country. Their task is to help maimed soldiers to regain control of injured muscles and nerves or of dormant or deranged mental faculties by appropriate physical exercises (physio-therapy) or by curative and diversional occupations (occupational therapy). The aides, who are headed by Miss Marian Morriss, number about 400, to whom others will be added as qualified applicants can be found.

Vieing with the reconstruction aides are the dieticians, whose section was organized about a year ago to take over from the pharmacists the victualing and food administration of the scores of military hospitals now handled by the Public Health Service. All

the members of the section, which is headed by Mrs. H. B. Corsette, are graduates of schools of household economics and are thoroughly trained and experienced in all matters relating to dieting. When fully recruited, the personnel will be about two hundred.

The nurses' corps, headed by Miss Lucy Minnegerode, consists of nurses who have been highly trained in every-day hospital work and a large proportion of whom are specialists in particular lines, such as mental and nervous diseases and tuberculosis. The corps today numbers 1,400 and needs 300 more. All applicants must, however, be graduates of recognized training schools, and must be registered either in the State in which they live or in that in which they were graduated.

Another body of nurses, 165 in number, who work in clinics and miscellaneous health activities under the supervision of Miss Ann Doyle, specializes in venereal disease treatment.

PERSONAL ITEMS.

Doctor Ralph N. Greene has retired as State Health Officer and opened offices in the St. James Building, Jacksonville. Doctor Greene will limit his practice to neurology and psychiatry.

Doctor Maurice E. Heck of DeLand is in Chicago taking a post-graduate course.

Doctor B. F. Barnes suffered a consider-

able loss in a recent fire at River Junction when he completely lost his office equipment.

Doctor B. Smart of Hosford recently underwent surgical treatment in a Jacksonville hospital. His many friends will be pleased that he is making an uninterrupted convalescence.

Doctor H. Mason Smith has recently severed his connections with the Florida Hospital for the Insane at Chattahoochee and opened offices in Tampa. Doctor Smith will confine his practice to neurology and psychiatry.

Doctor Gerry R. Holden of Jacksonville attended the meeting of the American Medical Association in Boston.

Doctor Robert L. Harris of Jacksonville has severed his connection with Doctor Marvin Smith's Sanitarium.

The mid-summer meeting of the Regular Board of Medical Examiners was held in Jacksonville June 13, 14.

Doctor T. Z. Cason attended the Boston meeting of the American Medical Association.

(At the solicitation of several of our members we have again inaugurated "Personal Items" as a feature. Complaints have been heard that *THE JOURNAL* has not kept the profession in touch with matters of personal interest to our membership. The success of "Personal Items" is entirely dependent upon the interest taken by the members. County Society Secretaries are especially urged to report their meetings in addition to any other items that can be picked up in their section.)

PUBLISHER'S NOTES

A GREAT HELP IN OBSTETRICS

The posterior lobe of the pituitary gland yields by extraction an agent of great value to obstetricians, for (1) preventing or arresting post-partum hemorrhage; (2) for overcoming uterine inertia or accelerating labor in delayed cases, and for dealing with surgical shock. Given hypodermically for such purposes, it is said to serve better than adrenalin for the reason that its effect is longer and more evenly sustained.

A solution thus injected has a contractile effect on smooth muscle fibres (as of the uterus) that is certain and decided. No doctor should be without it in his case or far from a supply when attending women in confinement, against emergencies he may have to meet any day. He should know how and when to use it; when he does he will be well prepared. It is not to be used in early labor but only when the pains are well

started, to excite uterine contractions and to make them more effective.

The Abbot Laboratories, Chicago, supply a reliable preparation. Their Pituitary Solution is made from selected glands and standardized to a definite strength. It may be had in ampules or in bulk containers.

A MATTER OF SECONDS

What pathologic phenomenon is more distressing to witness, more harassing to the anxious family, more exhausting and agonizing to the patient, than the acute paroxysm of asthma? When the physician is hastily summoned, frequently in the night, to minister to the sufferer, he is expected to relieve him at once, and failure of the means of relief is embarrassing, to say the least. Hence under these circumstances the physician must have an absolutely reliable and efficient agent at his immediate command.

The most available therapeutic agent in the acute paroxysm of asthma is the original Adrenalin Chloride Solution supplied for many years by Parke, Davis & Co. A hypodermic injection of a few minims of Adrenalin Solution promptly relaxes the bronchial spasm, supports the heart, stabilizes the vasomotor mechanism, and produces a calm, restful respite from the tumultuous, exhausting efforts of Nature to maintain the respiratory function.

Adrenalin is preferable to morphine because it does not narcotize the patient nor lock up his secretions. Furthermore, it is said that the asthmatic attacks do not occur

at such frequent intervals under Adrenalin treatment as when anodynes are employed. The action of Adrenalin treatment is startlingly prompt, and the effect has often been described by witnesses as magical—a much abused term, perhaps, but one that expresses the mental estimate of this remarkable drug by those who have had the good fortune to actually see what its effect is in such cases.

ACTIVE IMMUNIZATION INDUCES EXERCISE

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

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THE MEDICAL PRACTICE ACT.

A BILL TO BE ENTITLED

AN ACT to Establish a Composite Board of Medical Examiners for the State of Florida; to Define its Duties and Powers; to Regulate the Issuing and Recording of Licenses to Practice Medicine and Surgery in this State; to Define what is the Practice of Medicine and Surgery; to fix the Fees for Licenses Issued by said Board; to Provide for Revocation of Licenses and Cancellation of Recording of Same; to Repeal Section 2169 of the Revised General Statutes of Florida, Relating to Requirements to Obtain Certificates; Section 2170 of the Revised General Statutes of Florida, Relating to the Appointment of a Board of Eclectic Medical Examiners by the Governor; Section 2171 of the Revised General Statutes of Florida, Relating to the Examination of Applicants by said Eclectic Board; Section 2172 of the Revised General Statutes of Florida, Relating to the Duty of said Eclectic Board; Section 2173 of the Revised General Statutes of Florida, Relating to the Appointment of Medical Examiners; Section 2174 of the Revised General Statutes of Florida, Relating to the Qualifications of Members of the State Board of Medical Examiners; Section 2175 of the Revised General Statutes of Florida, Relating to the Terms of Office of the Members of the said Board; Section 2176 of the Revised General Statutes of Florida, Relating to the Election of a President and Secretary of said Board, and the Authority to make Rules for the Government thereof; Section 2177 of the Revised General Statutes of Florida, Relating to the Meetings of said Board; Section 2178 of the Revised General Statutes of Florida, Relating to Examinations by said Board; Section 2179 of the Revised General Statutes of Florida, Relating to Certificates issued by said Board; Section 2180 of the Revised General Statutes of Florida,

Relating to Temporary Certificates to Practice Medicine; Section 2181 of the Revised General Statutes of Florida, Relating to Duty of Member of said Board Granting Temporary Certificates; Section 2182 of the Revised General Statutes of Florida, Relating to Record of such Certificates; Section 2183 of the Revised General Statutes of Florida, Relating to Examination Fee; Section 2184 of the Revised General Statutes of Florida, Exemption of Excepting Certain Persons in the Provision of said Law; Section 5534 of the Revised General Statutes of Florida Relating to Violations of Law Regulating the Duties of Medical Examiners; Section 5535 of the Revised General Statutes of Florida, Relating to the Practice of Medicine as Physician without Certificate; And to prescribe Penalties for Violation of this

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF FLORIDA:

Section 1. That from and after the passage and approval of this Act, the following sections of the Revised General Statutes of Florida, to wit: Section 2169, relating to requirements to obtain certificates; Section 2170, relating to the appointment of a Board of Eclectic Examiners by the Governor; Section 2171, relating to the examination of applicants by said Eclectic Board; Section 2173, relating to the appointment of medical examiners; Section 2174, relating to the qualification of members of the State Board of Medical Examiners; Section 2175, relating to the terms of office of the members of the said Board; Section 2176, relating to the election of a president and secretary of said Board, and the authority to make rules for the government thereof; Section 2177, relating to the meetings of said Board; Section 2178, relating to examinations by said Board; Section 2179, relating to certificates issued by said Board; Section 2180, relating to temporary certificates to practice medicine; Section 2181, relating to duty of member of said

Board granting temporary certificates; Section 2182, relating to record of such certificate; Section 2183, relating to examination fee; Section 2184, exempting and excepting certain persons in the provisions of said law; Section 5534, relating to violations of law regulating the duties of medical examiners; Section 5535, relating to practice of medicine as physician without certificate; be, and the same and each of them, are hereby repealed in their entirety.

Section 2. **BOARD QUALIFICATIONS:** That a board is hereby established to be known by the name and style of the State Board of Medical Examiners; said board shall be composed of ten practicing physicians of integrity and ability, who shall be residents of and duly licensed to practice medicine in this state, and who shall have graduated from reputable medical schools and have been engaged in the active practice of their profession within this state for at least a period of five years, but none of them shall be connected in any way with the medical college; said board shall perform such duties and possess and exercise such powers relative to the protection of the public health and the control and regulation of the practice of medicine in the state as shall in this Act be prescribed and conferred upon it.

Section 3. **BOARD; HOW CONSTITUTED:** The Governor shall within thirty (30) days after the passage of this Act appoint ten physicians who shall possess the qualifications specified in Section 1 of this Act to constitute the members of this board. Five members of this board shall be allopath physicians, three shall be eclectic physicians, and two shall be homeopathic physicians.

The successor of each member shall be an appointee in the same manner.

Said members shall be so classified by the Governor that the term of office of two shall expire in one, three in two, two in three and three in four years from the date of appointment. Annually thereafter the Governor shall appoint two members, each of whom shall serve for a term of four years, and these appointments shall be made so as to preserve

the original ratio of allopaths, eclectics and homeopaths respectively. The Governor shall have power to remove from office members of the board for neglect of duty required by this Act, for incompetency or for unprofessional conduct. Any vacancy which may occur in said board in consequence of death, resignation, removal from the state or from other cause shall be filled for an unexpired term by the Governor in the same manner. A majority of the board shall constitute a quorum.

Section 4. **MEMBER; OATH OF OFFICE:** Immediately and before entering upon the duties of said office the members of the board shall take the constitutional oath of office and shall file the same in the office of the Secretary of State; and there shall thereupon issue to him a certificate of his appointment.

Section 5. **ORGANIZATION; MEETINGS:** That immediately after the appointment and qualification of said members, said board shall meet and organize. Said board shall elect a president, vice-president and a secretary-treasurer from its membership, whose salary shall be fixed and paid by the board. All expenses of the board shall be paid out of the funds collected by the board, and the remainder to be divided equally among the members of the board. Said board shall hold two regular meetings in each year, one meeting shall be in June at some central and convenient place in the state and on such date as the board shall select, of which meeting notice shall be given by publication thereof once a week for four successive weeks in a newspaper of general circulation throughout the state. The other meeting shall be held on the second Tuesday of October at the State Capitol. Call meetings may be held at the discretion of the president. Said board shall adopt a seal, which must be affixed to all licenses issued by it. The board shall from time to time adopt such rules and regulations as it may deem necessary for the performance of its duties, and shall examine and pass upon the qualifications of applicants for the practice of medicine in this state as herein prescribed.

Section 6. APPLICATION FOR LICENSE: Any person wishing to obtain the right to practice medicine in this state, who has not heretofore been registered or licensed so to do, shall, before it shall be lawful for him to practice medicine in this state, make application to the board through the secretary-treasurer thereof, upon such form, and in such manner as shall be adopted and prescribed by the board, and obtain a license from the board so to do. Unless such a person shall have obtained a license as aforesaid it shall be unlawful for him to practice medicine in this state, and if he shall practice medicine in this state, without first having obtained a license, he shall be deemed to have violated the provisions of this Act. All applicants for a license to practice medicine or for a renewal of any such license which has been revoked shall furnish the board with evidence of good moral character. Applications from candidates to practice medicine or surgery in any of its branches shall be accompanied with proof that the applicant is a graduate of a legally incorporated medical college or institution in good standing with the board.

Section 7. RECORDING LICENSE: Every license to practice medicine shall, before the licensee begins practice thereunder, be recorded in a book for that purpose in the office of the clerk of the circuit court of the judicial circuit in which he resides, or in which such practice is intended to be carried on. The clerk's fee for recording such a certificate shall be the same as for recording a deed. The clerk of each circuit shall make a report to the secretary of the board on the 31st day of December of each year of all certificates registered with him. Each applicant receiving a certificate from the board shall cause the same to be recorded within thirty (30) days.

Section 8. TEMPORARY LICENSE: In the discretion of the secretary-treasurer of said board, with the approval of the president, he may issue temporary license to an applicant, which shall have the same force and effect of

a permanent license until the next regular meeting of the board, when said license shall become void. Said license shall not be recorded.

Section 9. ACCREDITED COLLEGES: The board of medical examiners are hereby empowered under this act to pass upon the good standing and reputability of any college.

In determining the reputability of any medical college, the right to investigate and make a personal inspection of the same is hereby authorized.

Section 10. METHODS AND SUBJECTS OF EXAMINATION: The examination of applicants for license to practice medicine shall be made by said board according to the methods deemed by it to be the most practical and expeditious to test the applicants' qualifications. The board shall require the examination to be in writing. Each applicant shall be designed by a number instead of his name so that his identity shall not be disclosed to the members of the board until after the examination papers are graded. Examination shall be in the following subjects: Anatomy, physiology, chemistry, hygiene, surgery, therapeutics, obstetrics, gynecology, pathology, diagnosis, medical jurisprudence and practice of medicine.

Section 11. FEES: There shall be paid to the secretary-treasurer of said board by each applicant for license by examination a fee of twenty-five (\$25.00) dollars which shall accompany the application. The same fee shall be charged for issuing temporary license, which shall include the fee for examination for a permanent license, and a fee of fifty (\$50.00) dollars shall be charged for issuing a license by reciprocity. The board of examiners may grant a license without examination to licentiates or boards from other states, requiring equal or higher qualifications with the state of Florida, provided such shall have resided in this state for at least six (6) months prior to such application, and shall satisfy the board that it is his intention to become a bona fide resident and practitioner in this state. No part of any fee is returnable under any circum-

stances, nor shall this Act be construed as affecting or changing laws in reference to license tax to be paid by physicians and surgeons.

Section 12. POWERS OF BOARDS; PROSECUTIONS: The said board shall have power to administer oaths, to summon witnesses and to take testimony in all matters relating to its duties. Said board shall issue license to practice medicine to all persons who shall under the provision of this Act, and the rules and regulations under this Act, and the rules and regulations of the board. Such license shall be signed by the president and attested by the secretary-treasurer of the board under its adopted seal, and it shall give absolute authority to the person whom it is issued to practice medicine in this state. Every unrevoked license and indorsement of recordation made as provided in this Act shall be presumptive evidence in all courts and places the person therein named as legally licensed to practice medicine. It shall be the duty of the secretary-treasurer under the direction of the board, personally or by deputy to aid the prosecuting attorneys of the state in the enforcement of this Act and in the prosecution of persons charged with violation of its provision.

Section 13. REFUSAL TO GRANT LICENSE; REVOCATIONS: Said board may refuse to grant a license to practice medicine in this state, or may cause a licentiate's name to be removed from the records in the office of any clerk of court in this state on the following grounds: (a) the employment of fraud or deception in applying for license or in passing the examination provided for in this Act; (b) conviction of crime involving moral turpitude; (c) the practice of medicine under a false or assumed name, or the impersonation of another practitioner of a like or different name; (d) habitual intemperance in the use of ardent spirits, narcotics or stimulants to such an extent as to incapacitate him for the performance of his professional duties; (e) the procuring or aiding or abetting in procuring a criminal abortion; (f) the obtaining of a fee on representation that

a manifestly incurable disease be permanently cured; (g) causing the publication or the circulation of an advertisement of any medicine by means whereby the monthly periods of women can be regulated, or the menses, if suppressed, can be established; (h) causing the publication or circulation of advertisement relative to any disease of the sexual organs.

Proceedings for revocation of a license or the annulment of registration shall be begun by filing written charge or charges against the accused. These charges may be preferred by any person or corporation or the board may, on its own motion, direct the executive officer of said board to prefer said charges. Said charges shall be filed with the secretary-treasurer of said board; upon the filing of said charges as herein provided, a time and place for the hearing shall be fixed by said board as soon as convenient, and a copy of the charges, together with a notice of the time and place when they will be heard and determined shall be served upon the accused at least ten days before the date actually fixed for said hearing. At said hearing the accused shall have the right to cross-examine the witnesses against him, and to produce witnesses in his defense, and to appear personally or by counsel. Said board may, upon satisfactory proof that any licentiate has been guilty of any of the charges against him, suspend such a licentiate from the practice of medicine, and call in the license of said licentiate upon a two-thirds majority vote of the board; provided, however, that such suspended physician may have the proceedings of said board reviewed by a certiorari to the circuit court of the circuit in which said license is recorded. The accused shall have the right to demand a trial de novo before the circuit court and thereupon the court shall hear and determine the guilt or the innocence of the accused according to the evidence and law applicable to the facts which shall be produced before him, and unless reasonable doubt, the court shall render its decision in favor of the accused and restore to him all rights to practice under this Act.

Said writ shall issue upon the petition of the person whose license has been revoked, at any time within ninety (90) days after such revocation. Appeals from any decision of the circuit court may be taken to the supreme court of Florida in the same manner and subject to the same conditions as appeals in chancery are taken. In the event that any such license shall be revoked or registration annulled under the provisions of this Act, the said board shall forthwith transmit to the clerk of the circuit court or courts in which said accused is registered as a physician, a certificate under its seal, certifying that such registration has been annulled and such clerk shall, upon receipt of such certificate, file the same and forthwith mark such registration "Annulled."

Any person who shall practice medicine after his license has been revoked and registration annulled, shall be deemed to have practiced medicine without a license. However, at any time after six months from date of said conviction, said board may by a majority of vote issue a new license to the person affected, restoring or conferring all rights and privileges of and pertaining to the practice of medicine as defined and regulated by this Act; that the fee thereafter shall be the same as upon the issuance of the original license.

Section 14. DEFINITION OF PRACTICE OF MEDICINE: A person practices medicine within the meaning of this Act, except, as hereinafter stated, he hold himself out as being able to diagnose, treat, operate or prescribe for any human disease, pain, injury, deformity or physical condition. This Act shall not be construed to affect commissioned medical officers serving in the U. S. Army, Navy or Public Health Service while so commissioned, or any one actually serving without salary or professional fees on the resident medical staff of any legally incorporated hospital; or any legally registered dentist exclusively engaged in the practice of dentistry; or any person or manufacturer who without the use of drugs or medicines mechanically fits or sells lenses, artificial

eyes, limbs or other apparatus or appliances, or is engaged in the mechanical examination of eyes, for the purpose of constructing or adjusting spectacles, eye glasses or lenses; or any lawfully qualified physician in other states or countries meeting legally registered physicians in the state in consultation; or any physician duly registered in one county called to attend isolated cases in another county, but not residing or habitually practicing therein; or the furnishing of medical assistance in cases of emergency; or the domestic administration of family remedies; or the practice of chiropody; or osteopathy by osteopaths who have been duly licensed by the state board of Osteopath Examiners; or chiropractic by chiropractors, who have been duly licensed by the State Board of Chiropractic Examiners; or nurses or midwives; or the practice of religious tenets of any church.

Section 15. PENALTIES FOR VIOLATIONS: Any person guilty of practicing medicine in this state without complying with the provisions of this Act, or any person who shall violate the provisions of this Act, shall, upon conviction thereof, be punished by a fine not exceeding five hundred (\$500.00) dollars, or by imprisonment not exceeding one (1) year, or by both such fine and imprisonment, in the discretion of the court. Any person presenting or attempting to file as his own the certificate or diploma or credential of another, or who shall give false or forged evidence of any kind to the board or any member thereof in connection with an application for a license to practice medicine, or shall practice medicine under false or assumed name, or shall falsely impersonate another practitioner of a like or different name, shall, upon conviction thereof, be fined not more than one thousand (\$1,000.00) dollars, or by imprisonment for not more than five (5) years, or by both such fine and imprisonment, in the discretion of the court.

Section 16. All laws and parts of laws inconsistent herewith are hereby repealed.

Section 17. This Act shall take effect immediately upon its becoming a law.

Proceedings of the Forty-Eighth Annual Meeting of the Florida Medical Association Held at Pensacola, May 10, 11, 1921.

The Forty-eighth annual meeting of the Florida Medical Association was called to order by Dr. S. R. Mallory Kennedy, Chairman of the Local Committee on Arrangements, on May 10th, at 10:30 a. m. Rev. A. J. Moncrief, D. D., delivered the opening invocation.

The Chairman introduced Hon. M. G. Hoffman, President of the Pensacola Chamber of Commerce, who welcomed the Association to Pensacola, in behalf of the civic authorities.

Dr. Clarence Hutchinson, upon being introduced by the chair, delivered an address of welcome in behalf of the Escambia County Medical Society.

Dr. J. C. Vinson, of Tampa, responded in behalf of the Association.

The President, Dr. W. P. Adamson, of Tampa, assumed the chair, delivering his annual address, the theme of his address being "Preventive Medicine and the Trend of Practice."

Dr. Graham E. Henson read the following report of the Secretary:

Report of the Secretary.

To the President and Members of the Florida Medical Association:

GENTLEMEN—At the time of compiling this report twenty-eight counties out of forty-eight in the eleven councillor districts of the Association had filed their annual reports with the Secretary. The counties not having filed a report comprise: Santa Rosa in the first district; Franklin, Liberty and Wakulla in the second; Hamilton and Taylor in the third; Clay and Nassau in the fourth; Citrus and Hernando in the fifth; Pasco in the sixth; Osceola and St. Lucie in the seventh; Baker, Levy and Putnam in the eighth; Calhoun and Holmes in the ninth; Lee in the tenth.

The eleventh district, Dade, Monroe and Palm Beach, is the only district 100 per cent organized.

In view of the fact that of all these counties failing to render a report, there has been no time when they were organized, it is recommended that some action be taken by the House of Delegates to effect organization in these counties. In many of them the number of physicians resident in any one of the counties makes it impractical to effect single county units, and while the distances involved

might make it impractical for any combination of these counties to hold regular meetings if organization could once be effected, it would at least provide for the many physicians resident in these districts to remain affiliated with organized medicine. It is suggested that it might be well for the President to appoint a committee to redistrict the entire state.

The association has a membership of a few over six hundred. The custom of carrying delinquents for a period of one year, as has been the custom for some years, is a wise one; only occasionally does a member have to be dropped for non-payment of dues. This is demonstrated in the Treasurer's report showing a total of \$508.00 back dues collected during the past year.

In the matter of annual dues the Secretary is pleased to report that in only one instance did a county unit make any objection to the necessary increase made last year, and that the objections raised by this unit were not persisted in when the matter was fully explained. We have not lost a single member on account of the increase of dues.

While the Association could possibly operate under a reduction of dues during the coming year, it is recommended that they remain as fixed by the House of Delegates last year. Next year they can undoubtedly be reduced to four dollars and possibly to the pre-war assessment of three dollars.

Your Secretary attended a Conference of State Secretaries, called by the Board of Trustees of the American Medical Association, held in Chicago last November. The conference was well attended and the writer was well repaid for the time involved in attending this meeting. The American Medical Association is prepared to place a field man in this state to further organization if the Association so desires. The general scheme under which this work is carried on has been discussed before this body previously and it is believed you are all more or less familiar with it. The details will therefore not be discussed in this report, but the matter will be brought before the House of Delegates for their consideration.

It has been suggested by some of our members that it would be well at future meetings to curtail the opening exercises as they have been conducted for many years. Half a day is consumed under the present system, which takes valuable time from a two-day session. It has been found impractical to hold a three-day session. The suggestion has been made that at future meetings all addresses will be eliminated, the President's address following the call to order, in turn to be followed by proceeding with the business of the Association. As this would be a departure from a long established custom, an

expression of opinion from the Association would be of material value to subsequent Committees on Arrangements.

All of which is respectfully submitted,

GRAHAM E. HENSON, *Secretary*.

It was moved by Dr. L. M. Anderson that the report be accepted as information. The motion was duly seconded and carried.

The following report of the Treasurer was read:

Treasurer's Report.

To the President and Members of the Florida Medical Association:

GENTLEMEN—The following constitutes an accounting of the Association funds for the past year:

Balance on hand last annual report	\$ 496.41
Back dues collected during the year	508.00
Dues collected for current year	2,246.00
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	\$3,250.41
Expenses as per vouchers attached..	\$2,612.38
Balance on hand	638.03
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	\$3,250.41

GRAHAM E. HENSON, *Treasurer*.

It was moved by Dr. E. W. Warren that a committee of three be appointed to audit the account of the Treasurer. The motion was duly seconded and carried. The chair appointed Drs. E. W. Warren, W. M. Rowlett and L. M. Anderson.

The following report of the Editor was read:

Report of the Editor.

To the President and Members of the Florida Medical Association:

GENTLEMEN—THE JOURNAL, soon entering on its eighth year, is well established. During the war and the post-war period the publication had its difficulties. We are now rapidly approaching a pre-war basis, this not only in reference to the financing of THE JOURNAL but of the material furnished for publication. The scissors, to which special comment was made in the last annual report, have been successfully dispensed with and the reading matter published has for the most part been original. Through the efforts of Dr. McGinnis, one of the collaborators, permission was secured to publish Case Reports from the Massachusetts General Hospital. The contemplated raise in our advertising rates, as predicted in the last annual report, has been accomplished with the loss of only one former advertiser. The following financial statement is made a part of this report:

FINANCIAL STATEMENT OF THE JOURNAL OF THE
FLORIDA MEDICAL ASSOCIATION.

RESOURCES.

Balance cash on hand last annual report	\$ 71.86
Earnings from advertisements	1,540.24
Furniture	96.66
Cash from Florida Medical Association.	1,500.00
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	\$3,208.76

DISBURSEMENTS.

Expenses as per vouchers attached.....	\$2,766.32
Commissions	195.56
Discounts and Interest	42.84

ASSETS.

Furniture	96.66
Cash on hand	107.38
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	\$3,208.76

GRAHAM E. HENSON, *Editor*.

The chair directed the committee appointed to audit the accounts of the Treasurer to include in their report their audit of the financial affairs of THE JOURNAL.

The chair recognized Dr. W. M. Rowlett, of Tampa, who read the following joint report of the Regular Board of Medical Examiners and the Committee on Legislation and Public Health:

*Joint Report of the Regular Board of Medical Examiners and Legislative Committee,
Florida State Medical Association.*

GENTLEMEN—As executive officer of the Regular Board of Medical Examiners and member of the State Legislative Committee, I beg to make this brief report. As many of you know the work of the Regular Board of Medical Examiners has been full of hazards, though with the courage characteristic of the men associated with me, we have met and overcome them one by one, and now as I retire from office I look back with great pleasure upon my four years of association with such men as our late Dr. Van Hood and the others who composed our board. If through our efforts a better class of physicians have been admitted to our bounds and the state made a better place to live and practice medicine in we will feel repaid.

To fully appreciate our efforts would mean much time spent among our files. Among the most prominent acts of our administration have been: The placing of our board by the Federation of State Boards in the front rank; by keeping so close behind the diploma mills of the country and the outlawed colleges, that they have been in a constant state of turmoil and disorganization; also by keeping such close tab on certain other boards that they have had to resort to utmost secrecy, which has limited them in their manipulations.

We stood shoulder to shoulder against the retiring Governor and his officers when they ordered us to remove our restrictions and admit physicians to our state during the influenza epidemic. We have endeavored to aid the University of Florida in creating its pre-medical course. We condemned the fee system under which the boards in the past have been operated, and believe it should be a sufficient honor to serve without compensation, placing all fees collected in a fund that has been used to retain agents and lawyers, having prosecuted and defended over thirty cases, and taken steps whereby over fifty physicians and imposters have left the state or given up their practice. We have put an end to the tourist physician who has always been a disturbing factor, by refusing to issue temporary licenses. By discontinuing credits for years of practice the state has been saved from an old physicians' paradise. We have encouraged and endorsed the National Board of Medical Examiners, though reserve the right to re-examine any of their licensees, inasmuch as it is a non-legal board and possesses no lawful rights of existence. We do not wish to jeopardize the legal profession or embarrass ourselves by the possible chance of having a similar request made by some other that might spring up.

We have endeavored to interest the State Association in our behalf and feel that they should by some means be jointly connected. Working with your legislative committee with this point in view, we proceeded to formulate plans and succeeded in getting written opinions from all the recent candidates for Governor. A joint committee composed of Drs. Jackson, Peek, Fogarty, Warren and myself, later visited the Governor-elect and was happy to find him in perfect accord with the higher ideals of our profession, which was manifested in his message to the legislature. He has likewise assured the committee that recommendations from the Association would have prestige over all other applicants for medical positions, all of which goes to demonstrate the importance of unity of the Examining Board and the State Association.

Respectfully submitted,

WM. M. ROWLETT, *Secretary*,

Upon motion of the Secretary, the report was received as information. The motion was duly seconded and carried.

Dr. E. W. Warren made the following motion: "That the Association adjourn after tonight's meeting to go to Tallahassee for the purpose of appearing before the Senate Public Health Committee in the interests of the pending bill for a Medical Practice Act. The motion was seconded by Dr. Wm. E. Ross.

During the discussion of the motion, Dr. Albert H. Freeman offered the following substitute motion: "That we send our Legislative Committee to Tallahassee and (if they think advisable) that an additional five members be delegated to proceed to Tallahassee to advocate the passage of the pending bill, also that each member of the Association be urged to send a telegram to his senator urging support of the bill."

Dr. J. Harris Pierpont offered the following amendment to the substitute motion: "That the Legislative Committee be directed to proceed to Tallahassee to work in the interests of the Medical Examining Board Bill and that they employ such aid as they deem necessary."

The matter was freely discussed by Drs. E. W. Warren, F. Clifton Moor, John S. Helms, R. B. Harkness, Graham E. Henson, Albert H. Freeman, W. Herbert Adams, W. M. Rowlett, W. E. Ross, J. Harris Pierpont, Henry Palmer and Ralph N. Greene.

The President called Dr. Frederick J. Waas to the chair and took the floor in support of the substitute motion offered by Dr. Albert H. Freeman.

Dr. J. Harris Pierpont withdrew his amendment to the substitute motion, the latter upon vote being carried.

The President appointed Drs. F. Clifton Moor, Henry Palmer, Wm. E. Ross, J. Brown Farrier, Wm. S. Manning and Albert H. Freeman to accompany the Committee on Legislation and Public Policy to Tallahassee.

Upon motion, duly seconded, the Association adjourned.

SCIENTIFIC ASSEMBLY.

The Scientific Assembly was called to order at 2 p. m. by Dr. James D. Love, Chairman of the Pediatric Section, the following papers being read and discussed:

"Simplified Infant Feeding," F. Clifton Moor, Tallahassee.

"Vaccine Therapy in Pertussis," Wm. Edson Ross, Jacksonville.

"Diphtheria," B. L. Arms, Jacksonville.

"Indigestion of the Young Infant," J. H. Fellows, Pensacola.

The papers of Dr. M. B. Herlong, of Jacksonville, on "Hydrocephalus," and Dr. Grace Whitford, of Ozona, on "The Teaching of Personal Hygiene to Children," in the absence of the essayists, were read by title.

The election of Section Officers resulted in Dr. F. C. Moor being elected as Chairman and Dr. W. P. Adamson as Secretary.

The Section adjourned *sine die*.

HOUSE OF DELEGATES.

President Adamson called the House of Delegates to order at 4 p. m.

Organization was effected with the following representation:

Brevard—I. F. Bean, Melbourne.

Columbia—L. M. Anderson, Lake City.

Dade—J. B. Tower, Homestead; Mary Freeman, Perrine.

Duval—James H. Pittman, Jacksonville; Wm. E. Ross, Jacksonville; R. H. McGinnis, Jacksonville; Ralph N. Greene, Jacksonville; B. L. Arms, Jacksonville; J. D. Love, Jacksonville.

Escambia—J. S. Turberville, Pensacola; J. Harris Pierpont, Pensacola.

Hillsboro—John S. Helms, Tampa; J. C. Vinson, Tampa; J. B. Farrior, Tampa.

Leon—J. K. Johnston, Tallahassee.

Manatee—H. Gates, Bradentown.

Marion—George Dame, Jacksonville.

Palm Beach—F. B. Eurit, Stuart.

Polk—R. E. Wilhoyte, Lake Wales.

Suwannee—J. C. Davis, Jr., Quincy.

Volusia—W. C. Chowning, New Smyrna; J. B. Davis, Daytona.

Walton—D. H. Simmons, DeFuniak Springs.

A resolution was introduced providing that the two offices of Secretary and Editor be separated. In the discussion following the reading of the resolution it was brought out that the proposition involved several changes in the by-laws and was not in proper form for action. Upon motion, duly seconded, the House voted to table the resolution.

The House adjourned subject to the call of the President.

SCIENTIFIC ASSEMBLY.

The Scientific Assembly was called to order at 4:30 p. m. by Dr. J. Harris Pierpont,

the following paper being read and discussed:

"Florida's Program for the Eradication and Control of Venereal Diseases," George H. Dame, Jacksonville.

The scientific assembly then adjourned to the laboratory of the State Board of Health, where Dr. S. S. Spencer, of the United States Public Health, presented a paper entitled "Plague Eradication with Demonstrations." The Assembly adjourned until 9 a. m. the following day.

MAY 11th—SCIENTIFIC ASSEMBLY.

The Scientific Assembly was called to order at 9 a. m. by Dr. J. Harris Pierpont, of Pensacola, the following papers being read and discussed:

"Treatment of Cutaneous Growths: With a Consideration of Radium and X-Ray Therapy," J. L. Kirby-Smith, Jacksonville.

"The Physiological Basis for Radium Therapy," Gerry R. Holden, Jacksonville.

"Report on a Series of Fifty Operations on the Thyroid Gland," John S. Helms, Tampa.

"Pyuria," J. C. Vinson, Tampa.

"Ureteral Stricture: With Report of Cases," E. H. Teeter, Jacksonville.

"Two Anomalous Pregnancies," J. C. Davis, Quincy.

The Scientific Assembly adjourned until 2 p. m.

The President called the General Meeting of the Association to order at 12 noon, and announced the first order of business the election of officers and called for nominations for President.

Dr. Ralph N. Greene (Jacksonville): In selecting a President for this most dignified and august body, The Florida Medical Association, I think that, with the exception of the speaker, who received the honor of being elected President of the Association, few, if any, mistakes have been made in the past.

I realize the grave responsibility of carrying out the duties of President of this

Association and I may say that I know of no greater honor that can be conferred upon a man than that of being selected to serve as President of the Florida Medical Association.

In my case it was that of an ill wind blowing good, for shortly after being elected to the presidency of this society, I was called into military service and escaped much of the routine that would have otherwise fallen upon my shoulders.

We have with us today a man who has been loyal to organized medicine throughout his entire professional career. He has always been active in coming to the assistance of organized medicine whenever an emergency has happened to arise.

The gentleman, I have in mind, is, at the present time, a member of the United States Public Health Service, and because of this official connection it is necessary that he wear the uniform of the service he represents. He is, however, a native of Florida, a native of the city of Pensacola and a member of a very distinguished family.

In this city of Pensacola, he has labored to eradicate yellow fever. He has served with marked ability as a member of the State Board of Health of Florida. During the existence of bubonic plague in Pensacola, upon his shoulders rested the complete responsibility for the control of marine quarantine and the fumigation of all coast-wise and foreign vessels leaving this port, and the efficiency of his work has demonstrated the fact that not a single case has developed as coming from Pensacola.

The man I have in mind is my personal friend. I believe he is a personal friend of every man here. I believe he has the respect of every man here.

At this time, Mr. Chairman, I take great pleasure in placing in order of nomination the name of Dr. S. R. Mallory Kennedy, of Pensacola.

Dr. J. Harris Pierpont (Pensacola): Mr. President, it affords me unusual pleasure to second the nomination of Dr. Kennedy for the office of President. I have known Dr.

Kennedy for many years, and have ample opportunity to testify to his worth. He has the esteem and friendship, not only of the people of Pensacola, but the people of the state of Florida, and in honoring Dr. Kennedy the Medical Association honors itself. It gives me the greatest pleasure to second Dr. Kennedy's nomination.

Dr. Pittman (Jacksonville): I also want to second Dr. Kennedy's nomination, move that nominations be closed, and that the Secretary be authorized to cast the ballot of the Association for Dr. Kennedy.

The motion was seconded and carried.

The Secretary cast the ballot of the Association for Dr. S. R. Mallory Kennedy as President of the Association.

The President appointed Dr. J. Harris Pierpont and Dr. Ralph N. Greene, a committee to escort the newly elected President to the chair.

Dr. S. R. Mallory Kennedy: Gentlemen, I do not propose to make a speech. Words are inadequate to express my feelings at the present moment. I want to say to you, however, that I thank you very heartily for the nice things you have said, and what you have done. I realize, probably better than any one in the room, my limitations. I realize, that following such a President as you have had, how poor a President I will make, but with your assistance and cooperation we will "carry on," and I will try to do the best I can. I thank you all.

President Kennedy: The chair recognizes Dr. Helms:

Dr. John S. Helms (Tampa): Dr. Adamson, I assure you that it is one of the greatest pleasures of my life to present you with this Past-President's pin, and I take great pleasure in assigning you to the Society of Past Presidents, who, I am sure, will be glad to honor you as one of its members.

Dr. W. P. Adamson: I desire to thank Dr. Helms for his kind words, and the Society for its hearty cooperation during the year of my incumbency.

President Kennedy: Nominations are in order for First Vice-President.

Dr. Adamson (Tampa): Mr. President, I desire to place in nomination a man whom I have seen at these Associations year after year for quite a long period of time; a man who has always manifested quite an interest in all of the affairs of the Association, and who has always been interested in organized medicine. I speak of Dr. L. M. Anderson, of Lake City.

The nomination was duly seconded.

Dr. Adamson: I now move that nominations be closed and that the Secretary be instructed to cast the unanimous ballot of the Association for Dr. Anderson, as first Vice-President.

The motion was seconded and carried. The Secretary cast the ballot.

President Kennedy: Nominations for second Vice-President are now in order.

Dr. James H. Pittman (Jacksonville): I have in mind the name of one who never fails to attend the Association meetings and who is a valuable member of this society. I desire to place in nomination the name of Dr. W. Herbert Adams, of Jacksonville, as second Vice-President.

Dr. J. Harris Pierpont: I second the nomination of Dr. Adams, as second Vice-President, and move that the nominations be closed, and that the Secretary be instructed to cast the ballot of the Association for Dr. W. Herbert Adams.

The motion was seconded and carried.

The Secretary cast the ballot.

President Kennedy: Nominations are now in order for third Vice-President.

Dr. Graham E. Henson: Mr. President, I desire to place in nomination the name of Dr. J. C. Davis, Jr., of Quincy, for third Vice-President of this Association.

Dr. J. Harris Pierpont: I desire to second this nomination, move that the nominations be closed, and that the Secretary be instructed to cast the ballot of the Association for Dr. Davis, for third Vice-President.

The motion was seconded and carried. The Secretary cast the ballot.

President Kennedy: Nominations for Secretary-Editor are now in order.

Dr. J. Harris Pierpont: Having had the privilege of observing the conscientious and painstaking work of the Secretary, it therefore gives me great pleasure to put in nomination the name of Dr. Graham E. Henson, of Jacksonville, for Secretary-Editor.

The nomination was seconded by Dr. James H. Pittman and Dr. Ralph N. Greene.

It was moved that nominations be closed and that the unanimous ballot of the Association be cast for Dr. Graham Henson as Secretary-Editor of the Association by the President. The motion was duly seconded and carried.

President Kennedy: The chair takes great pleasure in casting the ballot of the Association for Dr. Henson as Secretary-Editor.

President Kennedy: There now remains to be selected a Delegate and Alternate to the meeting of the American Medical Association.

The Secretary: I think it is in order for this Association to select a good man as delegate to the House of Delegates, and when we have a good man to keep that man. Dr. John S. Helms, of Tampa, has held that office for two terms. The position is much the same as the position in any deliberative body, inasmuch as seniority counts for much and I therefore nominate Dr. Helms.

Dr. J. Harris Pierpont: I desire to heartily second that motion and move that nominations be closed, and that Dr. Helms be elected member of the House of Delegates to the National Association and that the Secretary be instructed to cast the unanimous ballot of the Association for Dr. Helms.

The motion was seconded and carried. The Secretary cast the ballot.

President Kennedy: Nominations are now in order for an alternate.

Dr. W. P. Adamson: I desire to place in nomination the name of Dr. J. Harris Pierpont, of Pensacola, as Alternate.

The nomination was seconded and carried and the motion was made that the nominations be closed and the ballot of the Association be cast for Dr. Pierpont as Alternate,

which motion was carried. The Secretary cast the ballot.

The following Councillors were then elected:

First District—Clarence Hutchinson, Pensacola.

Second District—F. C. Moor, Tallahassee.

Third District—Robert Harkness, Lake City.

Ninth District—J. C. Ryalls, Dellwood.

Eleventh District—Wm. R. Warren, Key West.

The next order of business being the selection of a meeting place for the next annual session, after some discussion the matter was left in the hands of the Executive Committee with power to act.

Dr. R. H. McGinnis offered the following resolution:

Resolved, by the Florida Medical Association in Convention assembled, That we express our appreciation and thanks for the delightful and most pleasant entertainment, and individual and collective consideration which has made the meeting at Pensacola most pleasurable and profitable. To the Escambia County Medical Society, to the citizens who loaned cars for our convention, to the Ladies' Committee of Entertainment, to Captain Christy, of the Naval Air Station, to Mr. Malcolm Yonge, the manager of the San Carlos Hotel, and to the Press of Pensacola, for all that has been done for the comfort, happiness and entertainment of the members of this Association, we tender our sincere thanks.

The resolution was unanimously carried.

Dr. Graham E. Henson: In meetings of this kind we have our glad moments and our sad ones. We have reached a sad moment at this time. A few weeks ago we were all grieved to hear of the death of one of our most valued members. He had long been active in this Association. It was a pleasure to meet with him and he was always willing to do his share. If the grim reaper had not intervened, he would have presided at our Scientific Assembly this year. Mr. President, I think it would be most fitting that the chair appoint a committee of three Past-Presidents of this Association to draw up fitting resolutions to the memory of our beloved

Dr. Murray W. Seagears, and I move that this be done.

The motion was seconded and carried.

The Chair appointed Past Presidents Ralph N. Greene, W. P. Adamson and E. W. Warren.*

Dr. James H. Pittman: Mr. President, I move that the chair appoint a sub-committee to draw up suitable resolutions on the death of any other members of this Association, which has taken place the past year.

The motion was seconded and carried.

The Chair appointed Drs. James D. Love, James V. Freeman and Wm. S. Manning.*

The Secretary read and moved the adoption of the following resolution:

The Florida Medical Association, an organization representing fifteen hundred physicians made up from representatives of the allopathic, homeopathic and eclectic schools, now in annual session in Pensacola, desires to go on record as endorsing and strongly urging the passage of House Substitute Bill four hundred and twenty-three without amendments—creating a Composite Board of Medical Examiners. This Bill has been carefully drawn with a view to absolute fairness to all and a protection to the sick and afflicted in the State.

The motion to adopt the resolution was duly seconded. Dr. John S. Helms objected to the use of the word "allopathic" in the resolution and offered an amendment to substitute therefor the word "regular." The secretary explained that the word objected to was purposely used on account of many legislators taking exception to the term "regular." Dr. Helms withdrew his amendment and the motion to adopt was carried unanimously.

The Auditing Committee presented the following report:

We, your Auditing Committee, beg to report that a careful audit has been made of the books of the Treasurer of the Association and those of the Secretary-Editor and find them correct and neatly kept.

(Signed) E. W. WARREN.
WM. M. ROWLETT.
L. M. ANDERSON.

*The reports of these committees are printed elsewhere in this issue.

The report of the committee, upon motion duly seconded, was received as information and the committee discharged.

The General Meeting of the Association, upon motion duly seconded, adjourned *sine die*.

SCIENTIFIC ASSEMBLY—2 P. M.

The Scientific Assembly was called to order by Dr. J. Harris Pierpont at 2 p. m., when the following papers were read and discussed:

"Gastropotosis," Seale Harris, Birmingham.

"The Gastro-Duodenal Tube," Robert B. McIvor, Jacksonville.

"Blood Stream Infections," James V. Freeman, Jacksonville.

"The Hodgen Splint," Robert Harkness, Lake City.

"Trachoma and Follicular Conjunctivitis," Alpheus K. Wilson, Jacksonville.

"Vertigo," M. A. Lischkoff, Pensacola.

In the absence of the essayists, the following papers were read by title:

"Some Remarks on the Administration of Silver Salvarsan," Ralph N. Greene, Jacksonville.

"The Professional, Ethical and Business Relation of Physician and Surgeon," R. R. Kime, Orlando.

Upon motion, duly seconded, the Scientific Assembly adjourned *sine die*.

PROPAGANDA FOR REFORM.

CHEMOTHERAPY OF TUBERCULOSIS AND THE "CERIUM SALT TREATMENT."—Koch studied the effects of many chemical substances, including a gold cyanid compound, on the growth of the tubercle bacillus in cultures, and concluded that all these substances remained completely inactive when tested upon the tuberculous animal. Compounds related to guaiacol and creosote came to have a widespread reputation as tuberculocidal agents without any one's taking the trouble to ascertain definitely whether they really had any particular capacity to injure tubercle bacilli in the test tube, the tuberculous animal

or the consumptive patient, although the German manufacturing chemists provided innumerable proprietary derivatives of these drugs. Some time before the war, a "complex lecithin-copper compound" of unannounced composition was put forward in Germany. Another copper cure came from Tokyo, "cyanocuprol" of Koga. Other copper compounds, such as copper arsphenamine, also were brought out. But none of these copper compounds have settled the tuberculosis problem. Recently, newspapers have given publicity to the treatment of tuberculosis by the so-called cerium earth salts in France. It appears that a few observations have been made on the inhibitory action on the growth of tubercle bacilli of salts of cerium and some other rare earth metals. The inhibitory action was less than that observed in the past for other chemical substances, and there is no record of experiments to determine their effect on experimental tuberculosis. Possibly cerium earth salts help the tuberculosis; the evidence so far presented, however, is nothing to get excited about. (*Jour. A. M. A.*, July 24, 1920, p. 246.)

GERMAN INSTITUTE FOR EXAMINATION OF PHARMACEUTICALS.—It is proposed that the commission founded years ago by the German internists—the *Arzneimittel Kommission*—is to be changed into an institution to investigate new pharmaceutical articles and supply information thereon to physicians on demand. An information bureau and bibliographic center is planned, and it is proposed to test new inventions for the manufacturers. The commission announces that it has been decided not to restrict the examinations to the chemical, pharmaceutical and pharmacologic side of the matter, but in given cases tests and investigations at the bedside will be made. It is stated that the pharmacologic investigations are to be made at the pharmacologic institute of the University of Berlin, which is in charge of Heffter, and that the institute is to be the headquarters of the new *Prüfungsamt*. (*Jour. A. M. A.*, December 25, 1920, p. 1791.)

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SECOND DISTRICT—F. Clifton Moor, M. D., Tallahassee . 1924
THIRD DISTRICT—R. M. Harkness, M. D., Lake City . . 1924
FOURTH DISTRICT—Julian E. Gammon, M. D., Jacksonville . 1922
FIFTH DISTRICT—H. Cutting Dozier, M. D., Ocala . . . 1922
SIXTH DISTRICT—Thomas Truelsen, M. D., Tampa . . . 1922
SEVENTH DISTRICT—Calvin D. Christ, M. D., Orlando . . 1922
EIGHTH DISTRICT—S. D. Rice, M. D., Gainesville . . . 1923
NINTH DISTRICT—C. H. Ryalls, M. D., Delwood 1924
TENTH DISTRICT—R. L. Cline, M. D., Arcadia 1923
ELEVENTH DISTRICT—W. R. Warren, M. D., Key West . . 1924

COMMITTEE ON SCIENTIFIC WORK.

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JOHN S. HELMS, M. D., F. A. C. S., *Tampa*
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F. J. WALTER, M. D., *Daytona*
E. W. WARREN, M. D., *Palatka*

PRESIDENT S. R. MALLORY KENNEDY.

Our newly elected President, Dr. S. R. Mallory Kennedy, of Pensacola, was born and reared in the city that is now his home. He faced the trials and tribulations of the world in 1878, born of an illustrious and honored parentage. He is well known to the profession as a good fellow and a prince of entertainers. With Mallory in the crowd, there is something stirring all the time. He received his degree of Doctor of Medicine in 1903 at Tulane University. Dr. Kennedy has been prominent in the medical affairs of his State for many years and has served as a member of the State Board of Health. He made an enviable record in the World War, serving for many months with the British forces and being cited by the British Commanding General for bravery in action. He was severely gassed and invalided to this country. He is at present with the United States Public Health Service with station in his home town.

The selection of Dr. Kennedy as President of the Florida Medical Association was a just recognition for service rendered.

THE STUART BILL

HOUSE SUBSTITUTE BILL NUMBER 423.

THE JOURNAL presents to its readers in this issue the full text of the new Medical Practice Act as it became a law. The original bill was introduced early in the session by Representative Stuart, of Hillsboro. Some amendments were made on the floor of the house but passed with little opposition. It went on to the senate as House Substitute Bill 423. Certain interests that have bitterly opposed for many years every effort on the part of the regular profession to secure the passage of a Medical Practice Act, were successful in getting the house to recall the bill from the senate after it had been in the upper branch of the legislature something over twenty-four hours. It was plainly evident that tactics had been started of the obstructive type. It was at this point that the power of organized medicine made itself

felt. The Florida Medical Association was in session at Pensacola, when the house voted to recall the bill, and immediately despatched to Tallahassee its Committee on Legislation and Public Policy, reinforced with a special committee of five additional members of the Association. They were successful in getting the house to reconsider their vote in recalling the bill from the senate. On the vote to recall the bill the house reversed its action and it remained in the senate where it had already reached the Committee on Public Health. At this point certain minor amendments were agreed to in committee by representatives of the Florida Medical Association and the bill, as amended, was favorably reported out by the senate committee and placed upon the calendar. The real fight for the passage of the bill and its enactment into law now commenced, a fight, not against the opposition which had been beaten to a frazzle but against Father Time. With many measures of more than general interest to be acted upon by the senate and with only a few days remaining before adjournment, there was great danger of the bill dying on the calendar. Civic organizations of Jacksonville, Tampa, Pensacola, Miami and from various other portions of the state came forward and added their strength to our forces. A perfect fusilade of telegrams reached the senate urging that the measure be made a special order of business and if possible passed without amendment. With but a few hours of life the senate faced a filibuster brought about concerning the passage of some local measure, but during the last evening prior to adjournment upon the call of districts, Senator Wilson gave way to Senator W. A. Russell, of Crescent City, who called up the bill. It was immediately passed as amended by the senate committee with a vote of 32 to 0. With Father Time getting in some deadly licks, the measure was immediately rushed over to the house which promptly concurred in the senate amendments and the fight was won. The Governor signed the bill on June 3d, when it became a law.

THE JOURNAL would not consider this re-

sume of the fight for the passage of this Act complete without referring to the splendid work done by two members of the Association. It was an Association victory and many played their part and did their bit, but it will be generally conceded that a great measure of our success was due to the splendid devotion and work carried on by Dr. Wm. M. Rowlett, of Tampa, Secretary of the Regular Board of Medical Examiners, and Past-President E. W. Warren, of Palatka. The work of these two gentlemen was carried on in an indefatigable manner at considerable personal sacrifice and they are surely deserving of a great measure of credit. We refer of course to work done outside the legislature and in committee rooms. In the lower branch of the legislature the work of Representative J. D. Raborn, of DeFuniak Springs, for many years an honored member of the Florida Medical Association, and that of Senator W. A. Russell in the upper house will be remembered in a grateful spirit by the Association for many years to come.

STATE HEALTH OFFICER

RAYMOND C. TURCK, M. D., F. A. C. S.

The appointment of Dr. Raymond C. Turck, of Jacksonville, as State Health Officer will be received by the medical profession of the state, and by all others who personally know the appointee, with sincere gratification, and it will be generally conceded without any disparagement toward those who have previously filled this office, that at no time has any previous State Board of Health made a wiser selection.

Dr. Turck needs no introduction to the members of his profession. He has been known for a great number of years as a man endowed with gifts far and above those possessed by the majority of men. To those who have had the privilege of close personal contact he is known as one of almost magic personal attraction and, of far more importance, as an individual who once having set out to attain a goal will persist in spite of any and all opposition and advance down the

field throwing aside all obstacles until the coveted line has been crossed. In short, he is a man of accomplishment and THE JOURNAL predicts that under his administration Florida will hold an enviable position on the map of Public Health activities of the United States.

While State Public Health work will be a new field for the activities of Dr. Turck, his experience as Division Sanitary Inspector of the Thirty-first Division of the United States Army during the World War will stand him in good stead. Indeed it was the enviable record made while serving his country under this assignment that earned him promotion and advancement to Division Surgeon of the Thirty-fifth Division, A. E. F., with which organization he served overseas. Dr. Turck has stated to THE JOURNAL that it is his ambition to keep the Public Health activities of the Florida State Board of Health upon as high a plane as they have ever been before. With this end in view, the individual work of every attache of the board throughout the state will be under close scrutiny. Efficiency will be the watchword and so far as possible, with such limitations as the board functions under present statutes, faithful service will receive its just reward.

The newly appointed State Health Officer has a wonderful opportunity to add laurels to those already won and THE JOURNAL feels sure that it is expressing the sentiment of organized medicine throughout the state in extending heartfelt congratulations on this appointment, not to the appointee alone but to the administration that has been fortunate enough to secure the services of a most valuable man to fill this most important public office.

A STANDARD TREATMENT FOR MALARIA.

The season is now at hand when malaria, endemic throughout the year in a goodly portion of the South, shows a marked increase in our morbidity rate. It is, therefore,

timely to urge upon physicians the adoption of the standard treatment of the disease recommended by the Sub-Committee on Medical Research of the National Malarial Committee. Physicians do not like to have their patients prescribe for themselves and very properly resent any suggestions from them regarding treatment. This is as it should be. The same spirit has been more or less manifest among physicians in adopting any standard treatment for malaria suggested by those having a large amount of clinical material upon which it was feasible to conduct a therapeutic study. This is not as it should be.

There are few diseases concerning which we have a more complete knowledge than malaria. This includes a thorough understanding of the mode of transmission and the life cycles of the parasites in both mosquito and man. There is no other disease in which we have at our command as complete a specific as we have in quinine for the treatment of malaria. However, in spite of these undeniable facts, we have made nothing like the progress that we should have in our fight for the control and eradication of this disease. Why? There may be several answers to the interrogation, but standing head and shoulders above all others is the fact that indifferent and inadequate treatment have been responsible in a greater measure for our continued morbidity and mortality rates than all other factors combined.

It is very desirable that physicians throughout the South adopt a standard treatment. The treatment suggested by the sub-committee may not be the best treatment, but to be able to formulate a better one it is very necessary that a large number of physicians give the one recommended a thorough trial and in so far as practical record their findings. Dr. C. C. Bass, of New Orleans, chairman of the subcommittee, has received reports from a goodly number of physicians, and they have practically all rendered favorable reports. It is sincerely hoped that Florida physicians will abandon the Tom, Dick and Harry methods of treating malaria and

universally adopt the standard treatment referred to.

The report of the Sub-Committee on Medical Research was signed by C. C. Bass, William Krauss, William H. Deaderich, George Dock and Charles F. Craig. In the report we read: "For the acute attack 10 grains of quinine sulphate by mouth three times a day for a period of at least three or four days, to be followed by 10 grains every night before retiring for a period of eight weeks. For infected persons not having acute symptoms at the time only the eight weeks' treatment is required. The proportionate doses for children are: Under one year, one-half grain; one year, 1 grain; two years, 2 grains; three and four years, 3 grains; five, six and seven years, 4 grains; eight, nine and ten years, 6 grains; eleven, twelve, thirteen and fourteen years, 8 grains; fifteen years or older, 10 grains.

The full report of this sub-committee will be found in Reprint No. 578, from the Public Health Reports, December 26, 1919, copies of which can be secured by addressing the Surgeon General of the United States Public Health Service, Washington, D. C.

THE NEW STATE BOARD OF HEALTH.

Governor Hardee appointed early during the month Dr. Calvin T. Young, of Plant City; Hon. Charles H. Mann, of Jacksonville, and Dr. F. C. Moor, of Tallahassee, as members of the State Board of Health.

THE JOURNAL is pleased to take this opportunity of congratulating Governor Hardee upon his splendid selections for this most important Board. Dr. Young has been a prominent member of the Florida Medical Association for many years and his past connection with Public Work in the State is familiar to all who interest themselves in such. Mr. Mann is a prominent business man of Jacksonville and his executive acumen will make him a most valuable member of the Board. Dr. F. C. Moor, a Past Presi-

dent of the Florida Medical Association, has for many years interested himself in everything that would tend to elevate the profession of the State. His appointment on the Board is a just recognition for valuable service rendered the people of the State in many instances.

The Board is a strong one; it is not believed that individually or collectively the State has ever had the benefit of a more efficient body of men to administer the health affairs of its people.

The Board met early in the month and selected Dr. Young as President of the Board; the selection of Dr. Raymond C. Turck for State Health Officer is a subject of editorial comment in another column.

PERSONAL ITEMS.

Dr. John S. Helms and Dr. J. C. Vinson, of Tampa, recently returned from Boston where they were in attendance at the meeting of the American Medical Association.

Dr. James M. Jackson, of Miami, was a recent visitor in Jacksonville.

The meeting of the Regular Board of Medical Examiners scheduled for June 13th and 14th in Jacksonville was not held. The bill creating a Composite Board of Medical Examiners, which became a law immediately upon approval by the Governor, automatically repealed laws under which the separate examining boards functioned. A committee appointed by President Kennedy to furnish a list of names to the Governor for his consideration in making his selections for this newly created board has completed its work and it is expected that before this issue of THE JOURNAL is off the press, the appointments will have been announced.

The proceedings of the second annual meeting of the Florida Railway Surgeons' Association were received too late to publish in this issue. They will appear in the July issue of THE JOURNAL.

MEMORIAM

MURRAY W. SEAGEARS, M. D.

WHEREAS, The life of our friend and fellow practitioner, Dr. Murray W. Seagears, was terminated when he was at the threshold of a period of his largest usefulness ; and,

WHEREAS, He rendered a distinguished service in behalf of suffering humanity ; and,

WHEREAS, His life and genial personality endeared him not only to his family but to a nation-wide circle of friends, both within and without the medical profession ; and,

WHEREAS, The results accomplished during the brief years of his service have inspired us all to higher endeavor and larger usefulness ; therefore be it

Resolved, That the Florida Medical Association has sustained an irreparable loss in his death ; and,

Resolved, That in giving expression to our sorrow we dedicate our services anew to the noble ends for which his life was given, so that while he rests from his labors his works do follow him ; and,

Resolved, That we extend to the members of his family the assurances of our deepest sympathy ; and, be it further

Resolved, That a copy of these resolutions be spread upon the records of the Florida Medical Association, published in the JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, submitted to the Press of Florida and presented to the bereaved family.

RALPH N. GREENE, M. D.,

Past President Florida Medical Association.

W. P. ADAMSON, M. D.,

Past President Florida Medical Association.

E. W. WARREN, M. D.,

Past President Florida Medical Association.

Resolved, That in the deaths of Dr. B. C. Dodds, of Sanford ; J. W. Nixon, of Chuluota ; Dr. B. V. Coffee, of Winter Haven, and Dr. Moses St. Peter, of Bunnell, the Florida Medical Association feels with keen sorrow that it has sustained a loss shared by the people of Florida and the medical profession in general.

That the Florida Medical Association testifies to the loyalty, ability, uprightness and devotion to duty that have formed a part of the lives of these departed members.

That they have lived the lives of honorable men and have borne with dignity and credit every professional burden imposed upon them.

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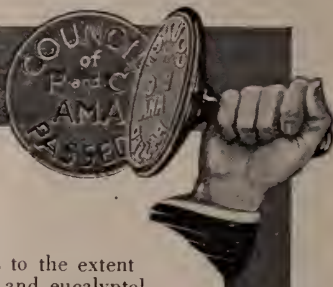
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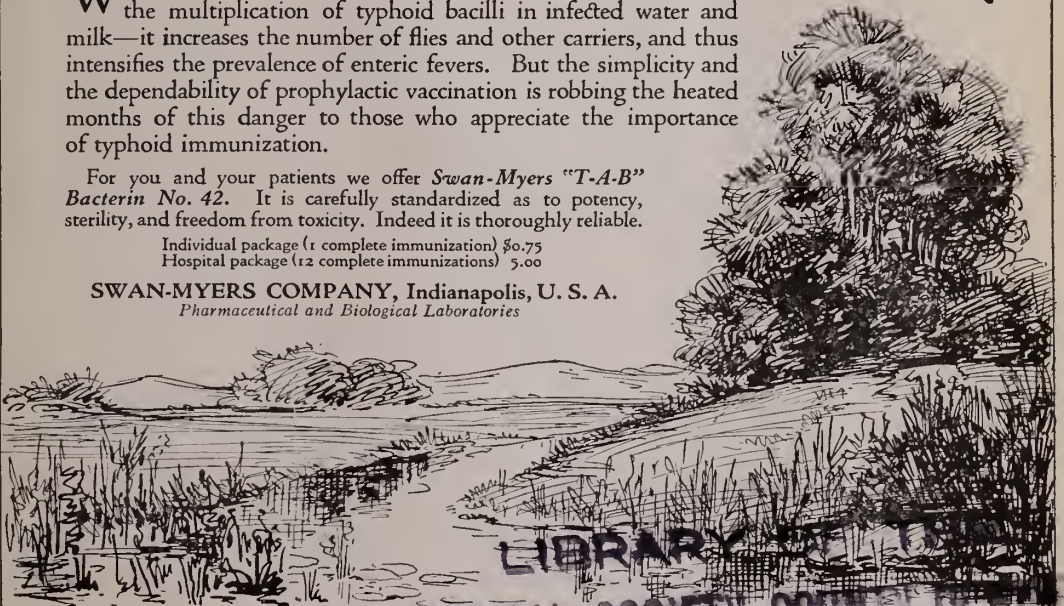
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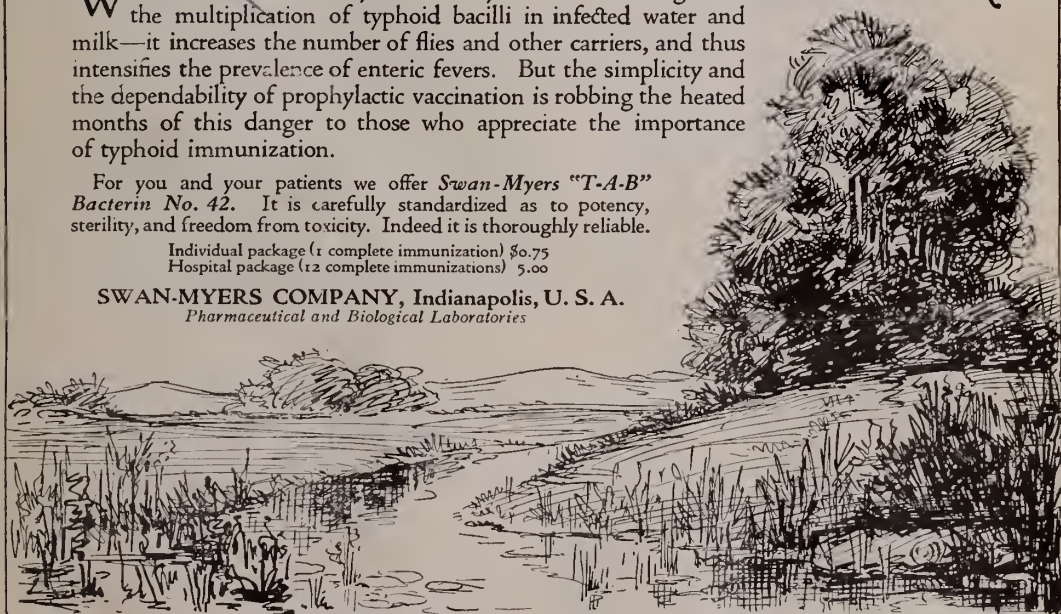
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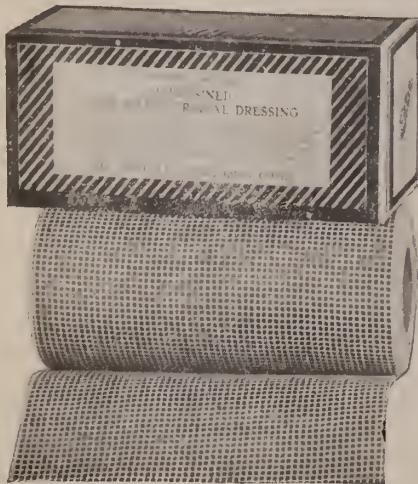
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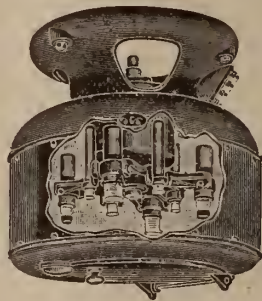
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